TOBACCO, ALCOHOL, & OTHER DRUG **2009 Report**

# Abuse Trends

## IN WASHINGTON STATE

Washington State Department of Social & Health Services

**DBHR** Division of Behavioral Health and Recovery
www.dshs.wa.gov/dasa

## NEW/CHANGING TRENDS

- Washington State has among the highest rates on non-medical use of prescription pain relievers in the nation. (page 69)
- There has been a significant increase in the percentage of individuals entering treatment within 30 days of discharge from detoxification services. (page 192)

**Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State**

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This report is also available on the
Division of Behavioral Health and Recovery website:
www.dshs.wa.gov/dasa

# Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State

# 2009 Report


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December 2009

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# *Message from the Governor*

*November 2009*

I am pleased to share with you the 2009 edition of *Tobacco, Alcohol, & Other Drug Abuse Trends in Washington State*. This report demonstrates the stake we all share in finding ways to combat the misuse of alcohol, tobacco, and drugs, which exact such a heavy tool upon Washington's communities.

This publication provides a wealth of information regarding the prevalence of substance abuse among youth and adults, as well as its effects upon our health and well-being. Addiction to alcohol, tobacco, and drugs is both a public health and public safety issue. It results in increased violence, crime, delinquency, birth defects, and illnesses. It inhibits economic vitality, saps our productivity and makes our efforts to improve education much more difficult.

Fortunately, as this Trends report makes clear, prevention strategies and treatment programs are working. In this difficult economic and budget climate, the investments we have made and continue to make in quality substance abuse prevention and treatment programs have borne fruit in lower medical and psychiatric costs, reduced social service costs, savings to our law enforcement and criminal justice systems, and enhanced worker productivity. They also help us fulfill our commitments to our children, ensuring they are able to take advantage of our investments in education.

As we prepare to meet our future challenges, I am acutely aware of the importance of having reliable and comprehensive information to assist decision-making at both the state and local level. This report serves as an important and valuable tool for distributing facts to guide us in our continuing efforts to build a safer, healthier Washington.

Sincerely,

Christine O. Gregoire
Governor

# Message from the Director

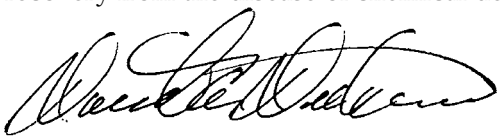
As the new director of the Division of Behavioral Health and Recovery (DBHR), it is a privilege for me to introduce the publication of this 17th edition of *Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State*. As this report profoundly demonstrates, the health, economic, and social, and health benefits resulting from the provision of quality substance abuse prevention and treatment services far outweigh the costs of providing them. Benefits include lower crime and criminal justice-related costs, lower medical costs and less reliance on public assistance, higher rates of employment and worker productivity, lower child welfare and social service costs, better school performance, lower school dropout rates, and reduced youth delinquency.

I am particularly gratified to see that, for the first time, the new *Trends* report is organized to reflect the "PITA" – prevention, intervention, treatment, and aftercare/support services – continuum. DBHR is committed to articulating and integrating a full continuum of care for individuals experiencing substance abuse problems, and to provide the supports necessary for them and their families to ensure recovery.

The *Trends* Report documents the effectiveness of these PITA efforts this sentence is confusing clean it up. Evidence-based prevention practices implemented in SFY 2008 will save the State more than $19 million during the lifetime of those served. Intervention services provided in 192 schools districts have proven their effectiveness in reducing binge drinking, and the use of alcohol, marijuana, and inhalants among students. Cost offsets in Medicaid from the expansion in treatment access authorized by the Legislature and Governor in 2005 totaled $21.7 million in SFY 2008. Support services made possible through the Access to Recovery (ATR) program enhance treatment and retention, and move patients toward healthier, more productive lives in their families and communities.

As we go forward, DBHR represents the integration of substance abuse and mental health-related services. Through this integration, we expect to be in a better position to both assess and treat patients with co-occurring mental health and chemical dependency disorders. Our longer term vision calls for the fullest possible integration of behavioral health and primary care services, creating a person-centered health care home for all Department of Social and Health Services clients able to meet all of their health needs.

Even under these difficult budgetary and economic conditions,  With the alarming increase in prescription drug abuse and continued misuse and abuse by individuals 18-25 there is more to be done. With our partners at the local, state, and federal levels, DBHR will persevere in our commitment to a healthier Washington. We look forward to the continuing opportunity to support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and supporting individuals in their recovery from the disease of chemical dependency.



David A. Dickinson

# The Division of Behavioral Health and Recovery: Mission and Strategic Goals

In 2008, the Division of Behavioral Health and Recovery (DBHR, formerly the Division of Alcohol and Substance Abuse (DASA)), with the assistance of a joint committee of the Citizens Advisory Council on Alcoholism and Drug Addiction and the Association of County Human Services and others, adopted a new Strategic Plan for 2009-2013. In doing so, DBHR revisited its Mission Statement to ensure that it continues to reflect the needs of Washington residents and the philosophy behind the Division's operations.

## *Mission*

The mission of the Department of Social and Health Services is to improve the safety and health of individuals, families, and communities by providing leadership and establishing and participating in partnerships. The Division of Behavioral Health and Recovery promotes strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency.

To succeed in its mission, the Division of Behavioral Health and Recovery is dedicated to building collaborative partnerships with communities, tribes, counties, service providers, schools, college and universities, the criminal justice system, and other agencies within the private sector and within local, state, and federal governments. The Division is committed to ensuring services are provided to individuals and communities in ways that are culturally relevant, and honor the diversity of Washington State.

To carry forth our mission, the Division of Behavioral Health and Recovery will:

- Develop policy options, and plan for the development and delivery of an effective continuum of chemical dependency prevention and treatment services.
- Provide and ensure quality services that support individuals and families in their efforts to raise children who are free of alcohol, tobacco, and other drugs.
- Educate communities about the importance of maintaining healthy lifestyles, and provide opportunities, tools and resources to enable communities to define and meet their local substance abuse prevention needs.
- Implement a continuum of intervention and treatment services to meet local, regional, tribal and statewide needs, and that specifically address the needs of low-income adults, youth, women, children, and families.
- Support continued recovery from addiction and a return to competitive employment by helping individuals surmount barriers to self-sufficiency.
- Develop standards, and assist providers in attaining, maintaining, and improving the quality of care for individuals and families in need of prevention, intervention, treatment, and aftercare services.

- Provide training and professional development opportunities for the chemical dependency field.
- Oversee and coordinate research that identifies need for publicly funded services, and assesses prevention and treatment outcomes, costs, and benefits.
- Design, develop, implement, and maintain management information services and decision support systems for internal and external customers.
- Manage available resources in a manner consistent with sound business practices.
- Advocate for enhanced resources for prevention, intervention, treatment, and aftercare services. These services serve as a primary avenue for protecting and promoting the public health and safety of all Washington residents.

## *Strategic Goals*

As part of its Strategic Plan and to serve its broad mission, the Division of Behavioral Health and Recovery has set five strategic priorities for 2009-2013:

- Reaffirm our commitment to evidence-based, targeted substance abuse prevention, and continue to implement efforts to combat underage drinking.
- Expand the range and location of intervention services available to non-chemically dependent, substance-abusing youth and adults.
- Assure delivery of a full range of high quality chemical dependency treatment services to adults and youth who are eligible and in need of them.
- Promote the wider availability of aftercare and support services to assist individuals in their recovery from alcohol and other drug addiction.
- Ensure an adequate, diverse, and competent workforce capable of meeting the substance use-related needs of Washington residents.

# Introduction

The Division of Behavioral Health and Recovery (DBHR) first published the *Tobacco, Alcohol, and Other Drug Abuse Trends Report* in 1993 as an effort to document and monitor Washington State's progress towards the ***Healthy People 2000: National Health Promotion and Disease Prevention Objectives***. Published in 1990, ***Healthy People 2000*** provided statistical milestones by which health policy makers and analysts can measure progress in the prevention of morbidity and mortality. A successor – ***Healthy People 2010*** – published by the U.S. Department of Health and Human Services, sets new objectives for the current decade.

***Healthy People 2000*** noted the significant impact that alcohol, tobacco, and other drugs have on the health of individuals and communities:

> Recognition and acknowledgement of the gravity of alcohol and other drug problems in the United States are changing the social climate. Almost every national opinion poll places alcohol and other drug problems as a priority concern, and the national effort to prevent these problems have mobilized government, schools, communities, businesses, and families...Progress will depend greatly upon increasing levels of education and awareness.[1]

Public education and awareness are integral parts of DBHR's goal – to reduce the likelihood of individuals becoming chemically dependent, and to provide an opportunity for chemically dependent persons to achieve and maintain recovery. This *Report* represents an important tool in our ongoing efforts towards this goal.

This is the 17th edition of *Tobacco, Alcohol, and Other Drug Abuse Trends.* We continue to expand and refine the *Report.* This year, we have organized the section on services to conform with the "PITA" (Prevention, Intervention, Treatment, Aftercare/Support Services) continuum. This reflects enhanced understanding of the need to embed substance abuse-related services within a recovery-oriented system of care. There is final data on the effectiveness of the Washington State Screening, Brief Intervention, Referral, and Treatment (WASBIRT) project, the federal assistance for which ended in 2008. A new section has been created to examine the extent of use of, and treatment for, prescription-type opiates, a problem that has now risen to new heights among both youth and adults. Data regarding the extent of substance use, substance use disorders, and need for treatment is updated. Areas where new or changed trends are now being identified are clearly marked.

[1] U.S. Public Health Service. Healthy People 2000: National Health Promotion and Disease Prevention Objectives, pp. 164-165. Washington, DC: U.S. Department of Health and Human Services, 1990.

The federal Controlled Substance Act (CSA) of 1970 gave Congress the authority to regulate the interstate commerce of drugs, and established five schedules that classify all substances, which were in some manner regulated under existing federal law. The placement of each drug is based upon the substance's medical use, potential for abuse, safety, and risk of dependence. The Act also provides a mechanism for substances to be controlled, or added to a schedule; decontrolled, or removed from control; and rescheduled or transferred from one schedule to another.

In determining into which schedule a drug or other substance should be placed, or whether a substance should be decontrolled or rescheduled, certain factors are required to be considered as follows:

- The drug's actual or relative potential for abuse.
- Scientific evidence of the drug's pharmacological effects.
- The state of current scientific knowledge regarding the substance.
- Its history and current pattern of abuse.
- The scope, duration, and significance of abuse.
- What, if any, risk there is to public health.
- The drug's psychic or physiological dependence liability.
- Whether the substance is an immediate precursor of a substance already controlled.

**Schedule I**

- The drug or other substance has a high potential for abuse.
- The drug or other substance has no currently accepted medical use in treatment in the United States.
- There is a lack of accepted safety for use of the drug or other substance under medical supervision.
- Some Schedule I substances are heroin, LSD, marijuana, and methaqualone.

**Schedule II**

- The drug or other substance has a high potential for abuse.
- The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
- Abuse of the drug or other substance may lead to severe psychological or physical dependence.
- Schedule II substances include morphine, PCP, cocaine, methadone, and methamphetamine.

**Schedule III**

- The drug or other substance has a potential for abuse less than the drugs or other substances in Schedules I and II.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.
- Anabolic steroids, codeine, and hydrocodone with aspirin or Tylenol, and some barbiturates are Schedule III substances.

**Schedule IV**

- The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule III.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.
- Included in Schedule IV are Darvon, Talwin, Equanil, Valium, Xanax, and Soma.

**Schedule V**

- The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule IV.
- The drug or other substance has a currently accepted medical use in treatment in the United States.
- Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV.
- Over-the-counter cough medicines with codeine are classified in Schedule V.

# Controlled Substances Uses and Effects

| Drugs | CSA Schedules | Trade or Other Names | Medical Uses |
|---|---|---|---|
| **NARCOTICS** | | | |
| **Heroin** | I | Diacetylmorphine, Horse, Smack | None in U.S., Analgesic, Antitussive |
| **Morphine** | II | Duramorph, MS Contin, Oramorph SR, Roxanol | Analgesic |
| **Oxymorphone** | II | Opana, Numorphan, Numorphone | Analgesic |
| **Codeine** | II, III, V | Empirin w/Codeine, Fiorinal w/Codeine, Robitussin A-C, Tylenol w/Codeine | Analgesic, Antitussive |
| **Hydrocodone** | II, III | Lorcet, Hycodan, Tussionex, Vicodin | Analgesic, Antitussive |
| **Hydromorphone** | II | Dilaudid | Analgesic |
| **Oxycodone** | II | OxyContin, Percocet, Percodan, Roxicet, Roxidodone, Tylox | Analgesic |
| **Methadone and LAAM** | I, II | Dolophine, Levomethadyl acetate, Orlaam | Analgesic, Treatment of Dependence |
| **Fentanyl and Analogs** | I, II | Alfenta, Duragesic, Innovar, Sufenta | Analgesic, Anesthetic |
| **Other Narcotics** | II, III, IV, V | Puprenex, Buprenorphine, Subutex, Suboxone, Darvon, Demerol, Opium, Talwin | Analgesic, Antidiarrheal, Treatment of Dependence |
| **DEPRESSANTS** | | | |
| **Chloral Hydrate** | IV | Noctec, Somnos, Felsules | Hypnotic |
| **Barbiturates** | II, III, IV | Amytal, Florinal, Nembutal, Seconal, Tuinal | Anesthetic, Anticonvulsant, Sedative, Hypnotic, Veterinary Euthanasia Agent |
| **Benzodiazepines** | IV | Ativan, Dalmane, Diazepam, Halcion, Librium, Paxipam, Rohypnol[2], Serax, Tranxene, Valium, Versed, Xanax | Antianxiety, Sedative, Anticonvulsant, Hypnotic |
| **Glutethimide** | II | Doriden | Sedative, Hypnotic |
| **Gamma Hydroxybutyrate[1]** | I | GHB, Georgia Home Boy, Liquid Ecstasy | None in U.S. |
| **Other Depressants** | I, II, III, IV | Equanil, Miltown, Noludar, Placidyl, Valmid, Soma | Antianxiety, Sedative, Hypnotic |

Source: U.S. Department of Justice, Drug Enforcement Administration

[1] Washington State Board of Pharmacy has GHB and related analogs included in Schedule III.
[2] Some of the following drug names are products that may contain other active agents.

| Physical Dependence | Psychological Dependence | Tolerance | Duration (Hours) | Usual Method | Possible Effects | Effects of Overdose | Withdrawal Syndrome |
|---|---|---|---|---|---|---|---|
| **NARCOTICS** | | | | | | | |
| High | High | Yes | 3 - 6 | Injected, Sniffed, Smoked | • Euphoria<br>• Drowsiness<br>• Respiratory depression<br>• Constricted pupils<br>• Nausea | • Slow & shallow breathing<br>• Clammy skin<br>• Convulsions<br>• Coma<br>• Possible death | • Watery eyes<br>• Runny nose<br>• Yawning<br>• Loss of appetite<br>• Irritability<br>• Tremors<br>• Panic<br>• Cramps<br>• Nausea<br>• Chills & sweating |
| High | High | Yes | 3 - 6 | Oral, Smoked, Injected | | | |
| High | High | Yes | Variable | Oral, Injected, Suppository | | | |
| Moderate | Moderate | Yes | 3 - 6 | Oral, Injected | | | |
| High | High | Yes | 3 - 6 | Oral | | | |
| High | High | Yes | 3 - 6 | Oral, Injected | | | |
| High | High | Yes | 4 - 5 | Oral | | | |
| High | High | Yes | 12 - 72 | Oral, Injected | | | |
| High | High | Yes | 10 - 72 | Injected, Trans-dermal Patch | | | |
| High-Low | High-Low | Yes | Variable | Oral, Injected | | | |
| **DEPRESSANTS** | | | | | | | |
| Moderate | Moderate | Yes | 5 - 8 | Oral | • Slurred speech<br>• Disorientation<br>• Drunken behavior without odor of alcohol | • Shallow respiration<br>• Clammy skin<br>• Dilated pupils<br>• Weak & rapid pulse<br>• Coma<br>• Possible death | • Anxiety<br>• Insomnia<br>• Tremors<br>• Delirium<br>• Convulsions<br>• Possible death |
| High-Mod. | High-Mod. | Yes | 1 - 16 | Oral, Injected | | | |
| Low | Low | Yes | 4 - 8 | Oral, Injected | | | |
| High | Moderate | Yes | 4 - 8 | Oral | | | |
| Unknown | Unknown | Yes | Dependent on dose | Oral, Snorted | | | |
| Moderate | Moderate | Yes | 4 - 8 | Oral | | | |

# Controlled Substances Uses and Effects

| Drugs | CSA Schedules | Trade or Other Names | Medical Uses |
|---|---|---|---|
| **STIMULANTS** | | | |
| Cocaine | II | Coke, Flake, Snow, Crack | Local anesthetic |
| Amphetamine/Methamphetamine | II | Adderall, Desoxyn, Dexedrine, Benzedrine, Vyvanse | Attention deficit disorder, narcolepsy, weight control |
| Methylphenidate | II | Ritalin, Concerta | Attention deficit disorder, narcolepsy |
| Khat (cathinone/cathine) | I, IV | Kat, Qat, Chat, Tohai, Tschat, Mirraa | None |
| Other Stimulants | II, III, IV | Adipex, Didrex, Ionamin, Melfiat, Meridia, Plegine, Prelu-2, Preludin, Sanorex, Tenuate, Tepanil | Weight control |
| **CANNABIS** | | | |
| Marijuana | I | Acapulco Gold, Grass, Mary Jane, Pot, Reefer, Sinsemilla, Thai Sticks | None |
| Tetrahydrocannabinol | I, II | Marinol, THC | Antinauseant |
| Hashish and Hashish Oil | I | Hash, Hash Oil | None |
| **HALLUCINOGENS** | | | |
| LSD | I | Acid, Boomers, Microdot, Trips | None |
| Mescaline & Peyote | I | Buttons, Cactus, Mescal | None |
| Amphetamine Variants | I | DOM, DOB, Ecstasy, MDA, MDMA, Nexus, STP | None |
| Phencyclidine & Analogs | I, II | Angel Dust, Hog, Loveboat, PCE, PCP, TCP | None |
| Ketamine | III | Ketaject, Ketalar | General anesthetic |
| Other Hallucinogens | I | Bufotenine, DMT, Ibogaine, Psilocybin, Psilocyn | None |
| **ANABOLIC STEROIDS** | | | |
| Testosterone (Cypionate, Enanthate) | III | Androderm, Delatestryl, Depo-Testosterone | Hypogonadism |
| Nandrolone (Decanoate, Phenpropionate) | III | Deca-Durabolin, Durabolin, Nortestonsterone | Anemia, Breast cancer |
| Oxymetholone | III | Anadrol-50 | Anemia |



Source: U.S. Department of Justice, Drug Enforcement Administration; National Institute on Drug Abuse

| Physical Dependence | Psychological Dependence | Tolerance | Duration (Hours) | Usual Method | Possible Effects | Effects of Overdose | Withdrawal Syndrome |
|---|---|---|---|---|---|---|---|
| **STIMULANTS** | | | | | | | |
| Possible | High | Yes | 1 - 2 | Sniffed, Smoked, Injected | • Increased alertness<br>• Excitation<br>• Euphoria<br>• Increased pulse rate & blood pressure<br>• Insomnia<br>• Loss of appetite | • Agitation<br>• Increased body temperature<br>• Hallucinations<br>• Convulsions<br>• Possible death | • Apathy<br>• Long periods of sleep<br>• Irritability<br>• Depression<br>• Disorientation |
| Possible | High | Yes | 2 - 4 | Oral, Injected, Smoked | | | |
| Possible | High | Yes | 2 - 4 | Oral, Injected | | | |
| Unknown | Moderate | Possible | 1 - 2 | Oral | | | |
| Possible | High | Yes | 2 - 4 | Oral, Injected | | | |
| **CANNABIS** | | | | | | | |
| Unknown | Moderate | Yes | 2 - 4 | Smoked, Oral | • Euphoria<br>• Relaxed inhibitions<br>• Increased appetite<br>• Disorientation | • Fatigue<br>• Paranoia<br>• Possible psychosis | • Occasional reports of insomnia<br>• Hyperactivity<br>• Decreased appetite |
| Unknown | Moderate | Yes | 2 - 4 | Smoked, Oral | | | |
| Unknown | Moderate | Yes | 2 - 4 | Smoked, Oral | | | |
| **HALLUCINOGENS** | | | | | | | |
| None | Unknown | Yes | 8 - 12 | Oral | • Illusions and hallucinations<br>• Altered perception of time and distance | • More intense "trip" episodes<br>• Psychosis<br>• Possible death | • Unknown |
| None | Unknown | Yes | 8 - 12 | Oral | | | |
| Unknown | Unknown | Yes | Variable | Oral, Injected | | | |
| Unknown | High | Yes | Days | Oral, Smoked | | | |
| Unknown | Unknown | Yes | Variable | Injected, Oral, Smoked | | | |
| None | Unknown | Possible | Variable | Smoked, Oral, Injected, Sniffed | | | |
| **ANABOLIC STEROIDS** | | | | | | | |
| Unknown | Unknown | Unknown | 14 - 28 Days | Injected | • Virilization<br>• Acne<br>• Testicular atrophy<br>• Gynecomastia<br>• Agressive behavior<br>• Edema | • Unknown | • Possible depression |
| Unknown | Unknown | Unknown | 14 - 21 Days | Injected | | | |
| Unknown | Unknown | Unknown | 24 | Oral | | | |

# Street Prices for Illicit Drugs, 2008

| DRUG | UNIT | AVERAGE STREET PRICE | RANGE |
|---|---|---|---|
| Heroin | GRAM<br>OUNCE | $62<br>$772 | $30-$100<br>$270-$2,200 |
| Cocaine | GRAM<br>OUNCE | $61<br>$782 | $40-$100<br>$500-$1,200 |
| Methamphetamine | GRAM<br>OUNCE | $80<br>$991 | $40-$100<br>$800-$1,275 |
| Cannabis | GRAM<br>OUNCE | $15<br>$245 | $10-$25<br>$125-$400 |

Source: Northwest High Intensity Drug Trafficking Area (HIDTA), *Threat Assessment and Strategy for Program Year 2010.*

The Northwest High Intensity Drug Trafficking Area (HIDTA) periodically gathers data on both street prices and availability of common illicit drugs of abuse. Information is compiled from the Drug Enforcement Agency, U.S. Border Patrol, area narcotics taskforces, sheriff's offices, police departments, and the Coast Guard. Both price and availability can vary widely, both by region and by county.

# New/Changing Trends for 2009

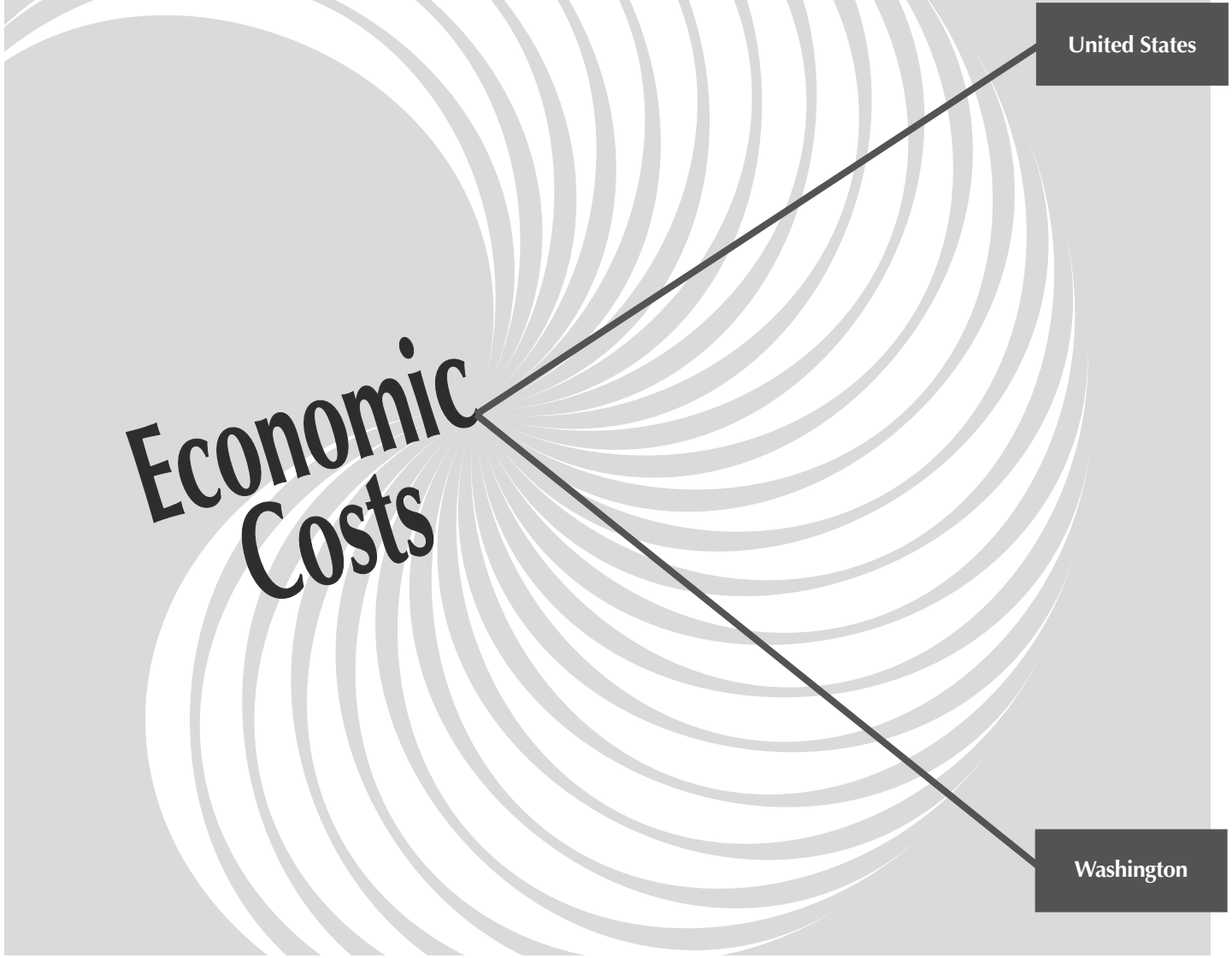
Preparation of the *Trends Report* annually makes it possible to examine data for new or changing trends. Such trends can mark the success of failure of a recent legislative effort, a new intervention or change in public health practice, or changes in behavior. They may point the way toward increased need for surveillance, research and analysis, or reorientation in the delivery of public services.

For 2009, the following new or changing trends are worthy of note:

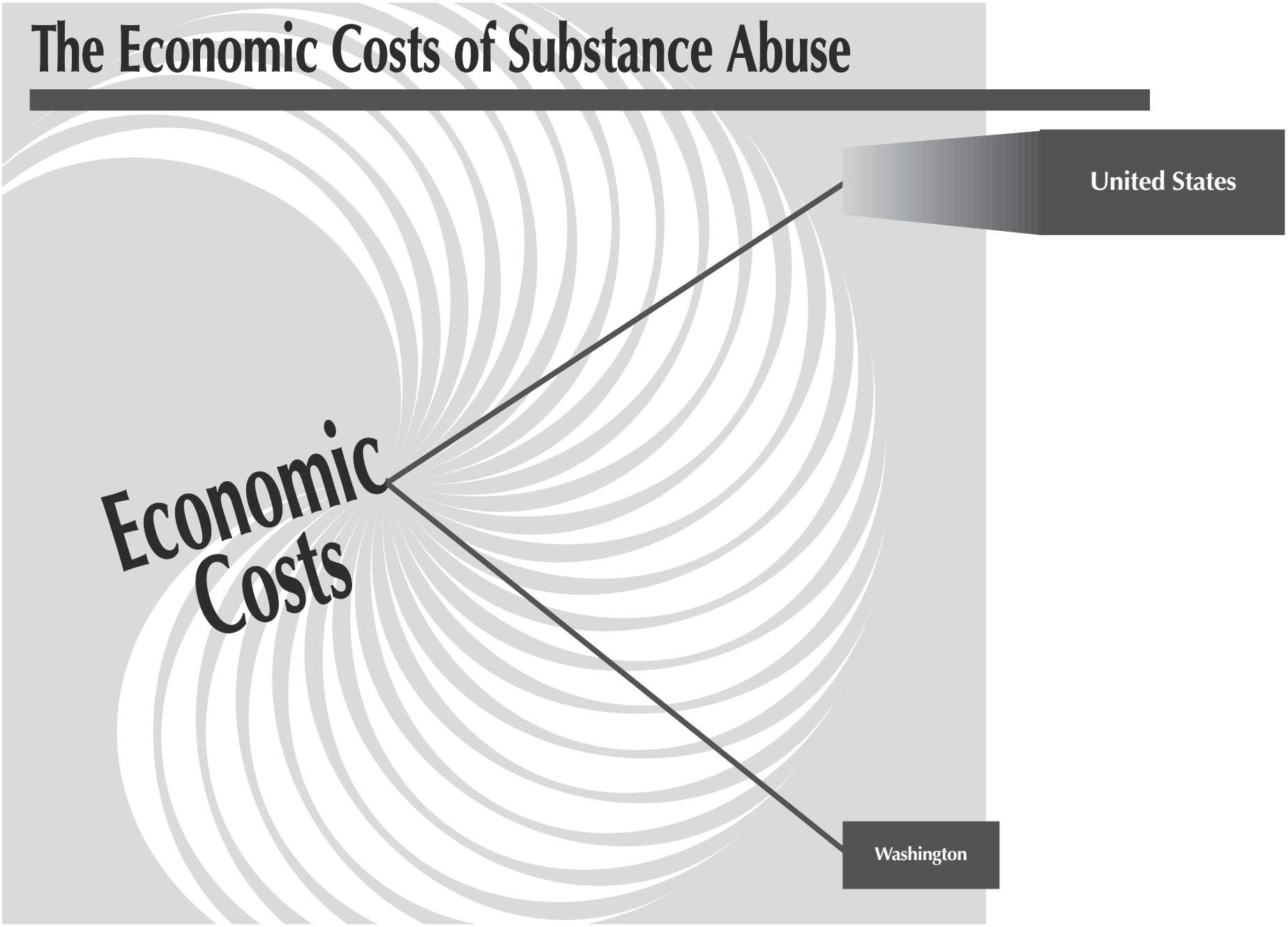
- In 2005, 11.2% of total federal and state government spending was spent on tobacco, alcohol, and other drug abuse and addiction and its consequences. (page 5)
- In 2005, only 1.9% of federal and state government spending on substance abuse and its impacts went for prevention and treatment. (page 6)
- In 2005, Washington State spent $3.2 billion on services related to substance abuse and its impacts. (page 18)
- Substance abuse results in higher state government spending on education, criminal justice, and health. (page 19)
- Past 30-day marijuana use among Washington students is increasing (page 41)
- Methamphetamine use among Washington high school students is declining. (page 44)
- Steroid use among students in Washington State is increasing. (page 45)
- Lifetime inhalant use among Washington State students has increased. (page 46)
- About one in eight Washington 12$^{th}$ graders used prescription pain relievers to get high in the past 30 days. (page 48)
- There is an association between use of Ritalin without a prescription and use of prescription pain relievers to get high. (page 49)
- One-fifth of Washington 12$^{th}$ graders reported being drunk or high in school in the past year. (page 50)
- Washington State has among the highest rates of non-medical use of prescription pain relievers in the nation. (page 69)
- Adult smoking among both men and women has declined substantially in the past decade. (pages 70-73)
- The drug-induced death rate in Washington is increasing rapidly. (page 92)
- The number of drug-caused deaths involving prescription-type opiates in Seattle-King County is five times higher than a decade ago. (page 95)

- The number of drug-caused deaths in Seattle-King County in which methamphetamine is involved is now declining. (page 97)
- Seattle emergency department visits related to cocaine use have been increasing. (page 99)
- Even low levels of alcohol consumption are linked with breast cancer. (page 103)
- Deaths from Hepatitis C (HCV) are rising rapidly. (page 113)
- Deferred prosecution, including chemical dependency treatment, results in reduced DUI recidivism. (page 122)
- Robberies of Washington pharmacies have increased six-fold since 2003. (page 124)
- Arrests for property crime are declining rapidly. (page 126)
- The teen birth rate in Washington State has risen significantly. (page 140)
- There has been a significant increase in the percentage of individuals entering treatment within 30 days of discharge from detoxification services. (page 192)
- Adult and youth treatment admissions for methamphetamine are falling. (pages 229, 256)
- Two-thirds of youth admitted to treatment were involved in the criminal justice system at time of admission (page 257)
- The abuse and consequences of abuse from prescription-type opiates in Washington State are increasing precipitously, as are treatment admissions. (pages 301-307)
- In SFY 2008, almost four out of ten admissions to publicly funded treatment for prescription-type opiate addiction were for young adults ages 18-25. (page 307)
- Providing treatment for ADATSA clients results in reduced crime victim and criminal justice system costs. (page 340)
- In SFY 2008, total medical savings for treatment expansion patients receiving chemical dependency treatment was $21.7 million. (page 347)
- Providing treatment to GA-U clients results in reduced crime victim and criminal justice system costs. (page 357)
- Providing treatment to low-income clients results in reduced crime victim and criminal justice system costs. (page 360)
- More than three-quarters of patients receiving opiate substitution treatment in SFY 2008 were retained for a least one year. (page 366)

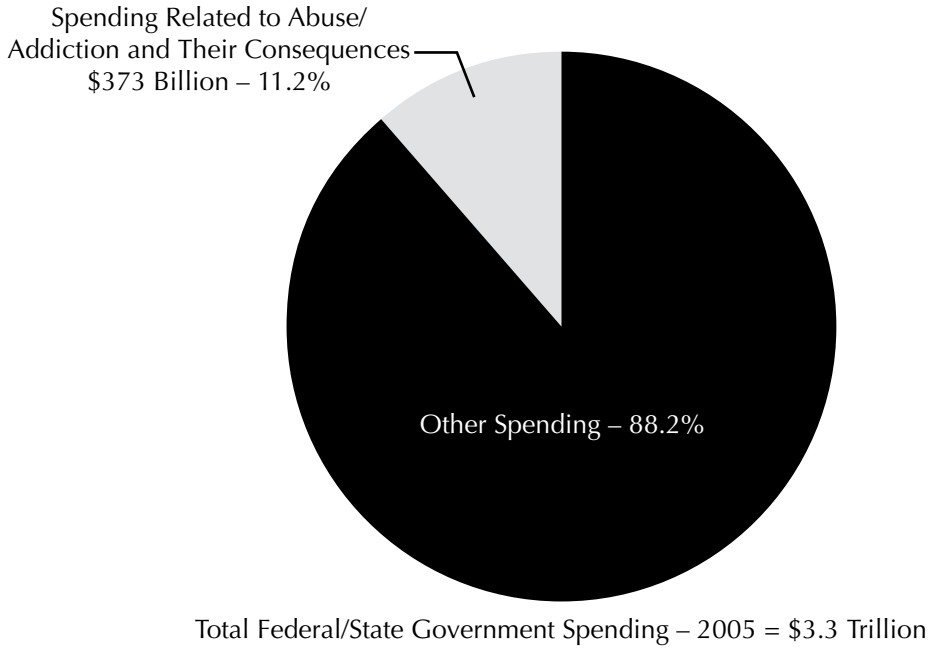
# The Economic Costs of Substance Abuse



# The Economic Costs of Substance Abuse



# In 2005, 11.2% of Total Federal and State Government Spending was Spent on Tobacco, Alcohol, and Other Drug Abuse and Addiction and Their Consequences.



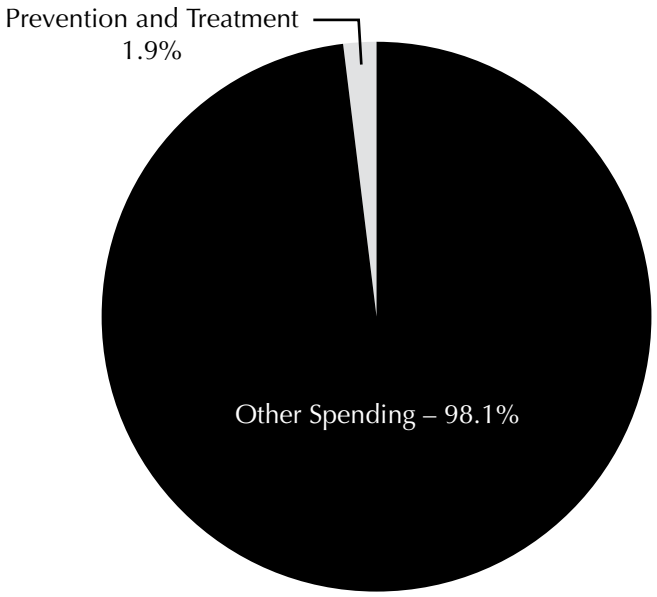

Source: National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets,* 2009.

A 2009 national study found that in 2005, the federal government spent $238.2 billion (9.6% of its budget) on dealing with the impacts of substance abuse and addiction. State governments spent $135.8 billion (15.7% of their budgets). These included crime and criminal justice, health care, child abuse, domestic violence, homelessness, education, and other related costs. For every dollar federal and state governments spent on prevention and treatment, they spent $59.83 on dealing with the consequences.[1]

[1] National Center on Addiction and Substance Abuse at Columbia University (CASA). *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets.* New York, NY: CASA, May 2009.

NEW/CHANGING TREND

# In 2005, Only 1.9% of Federal and State Government Spending on Tobacco, Alcohol, and Other Drug Abuse and Addiction and Its Consequences Went for Prevention and Treatment.




Total 2005 Federal and State Government Spending Related to Substance Abuse – $373.9 Billion

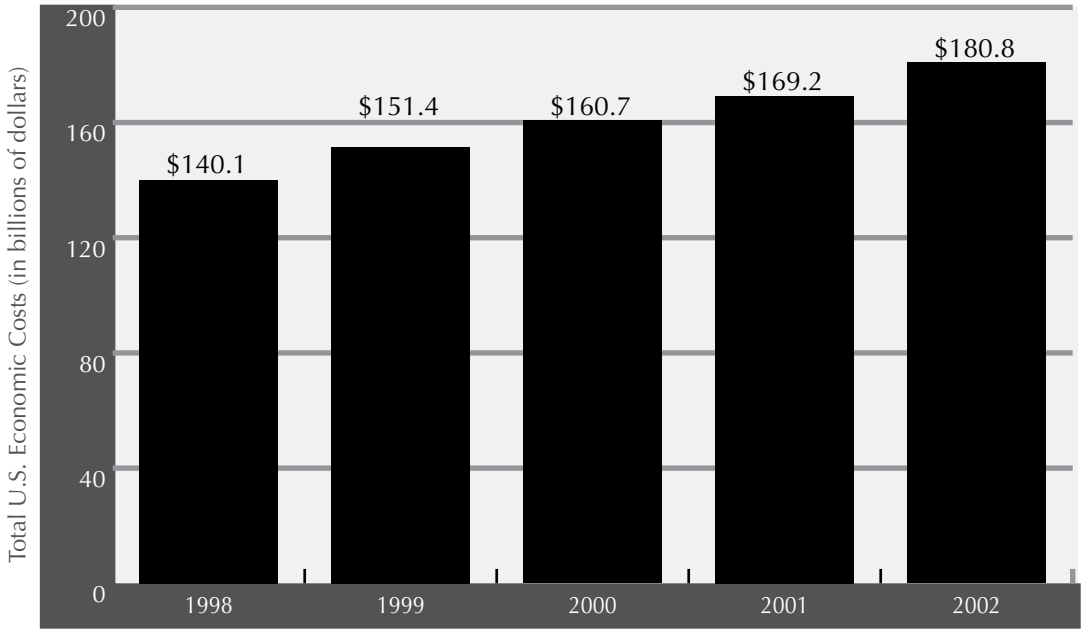
Source: National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets,* 2009.

A 2009 national study indicates that only a small fraction of federal and state government spending related to tobacco, alcohol, and other drug abuse was used for prevention and treatment. The majority went to deal with the consequences of abuse and addiction, in health care, crime and criminal justice, social service, mental health, and education costs, with much smaller amounts spent on addiction-related research and drug interdiction.[1]



[1] National Center on Addiction and Substance Abuse at Columbia University (CASA). *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets.* New York, NY: CASA, May 2009.

# Through 2002, the National Economic Costs of Drug Abuse Continued to Rise.

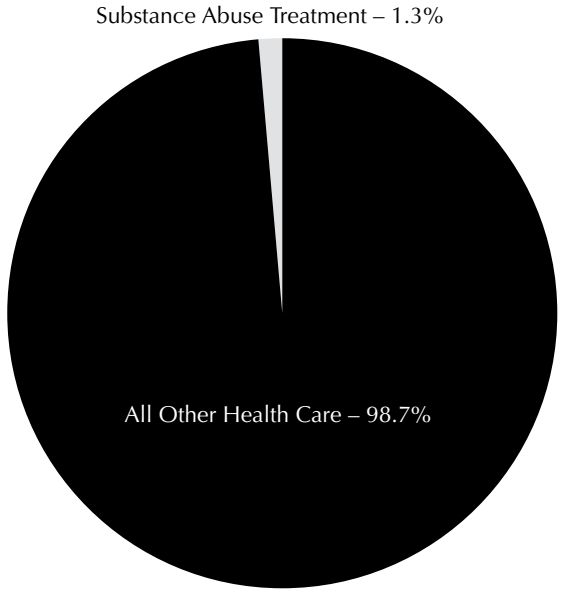



Source: Office of National Drug Control Policy, *The Economic Costs of Drug Abuse in the United States*, 1992-2002. Washington, DC: Executive Office of the President, 2004.

Total U.S. economic costs related to drug abuse (independent of tobacco use and alcohol abuse and alcoholism) rose more than 5.3% a year between 1992-2002. The largest portion of costs is productivity-related, representing 71.2% of the total, the greatest share of that being related to criminal activity. In addition, total costs for drug-related state and federal corrections were $14.2 billion, the bulk for the operation of prisons. In 2002, there were almost 330,000 individuals incarcerated for drug-specific offenses, and an estimated 135,000 for income-generating or other crimes related to drug abuse. That year, approximately two million individuals were arrested for drug-related offenses or drug abuse-related crimes.[1]

[1] Office of National Drug Control Policy. *The Economic Costs of Drug Abuse in the United States, 1992-2002*. Washington, DC: Executive Office of the President, 2004.

# Nationally, Only 1.3% of the Almost $1.4 Trillion Spent on Health Care in the United States Goes for Substance Abuse Treatment.



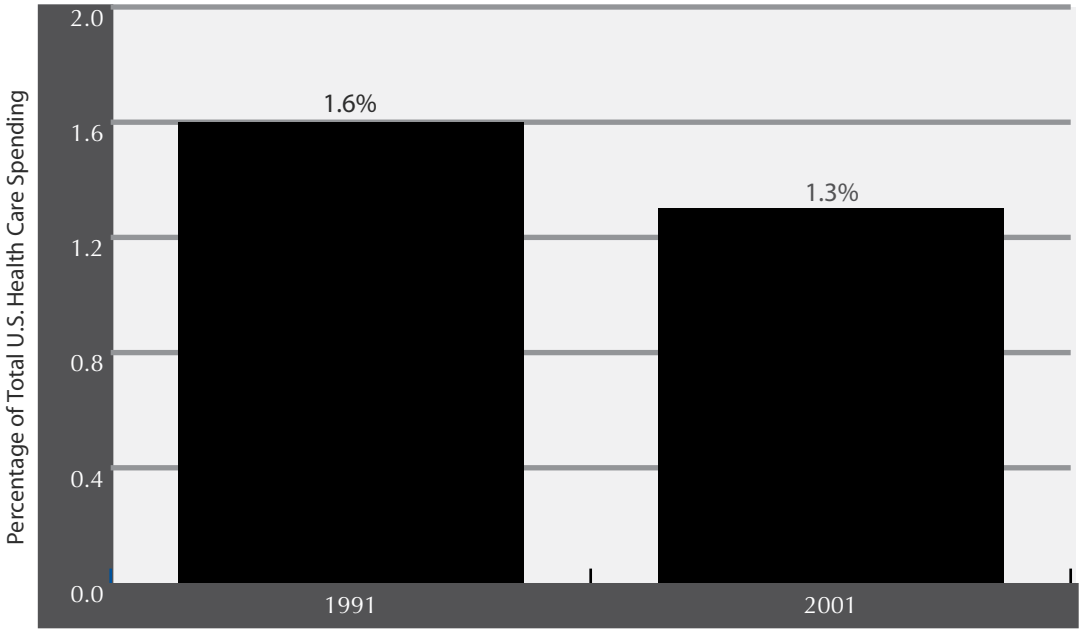

Total 2001 U.S. Health Care Spending – $1.37 trillion

Source: Mark, T. et al., "U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001." *Health Affairs* – Web Exclusive, 2005.

A 2005 study published in the journal *Health Affairs* found that of the $1.37 trillion spent on health care in the United States in 2001, only $18.3 billion (1.3%) went for substance abuse treatment.

Despite scientifically demonstrated cost offsets in decreased mortality, lower crime and criminal justice costs, higher worker productivity, less reliance on public assistance and other social services, fewer medical and psychiatric hospitalizations and emergency room visits, and lower health care costs, chemical dependency treatment remains extremely underfunded at both the state and federal level.

# As a Percentage of Total U.S. Spending on Health Care, Spending on Substance Abuse Treatment Declined 14.5% Between 1991 and 2001.



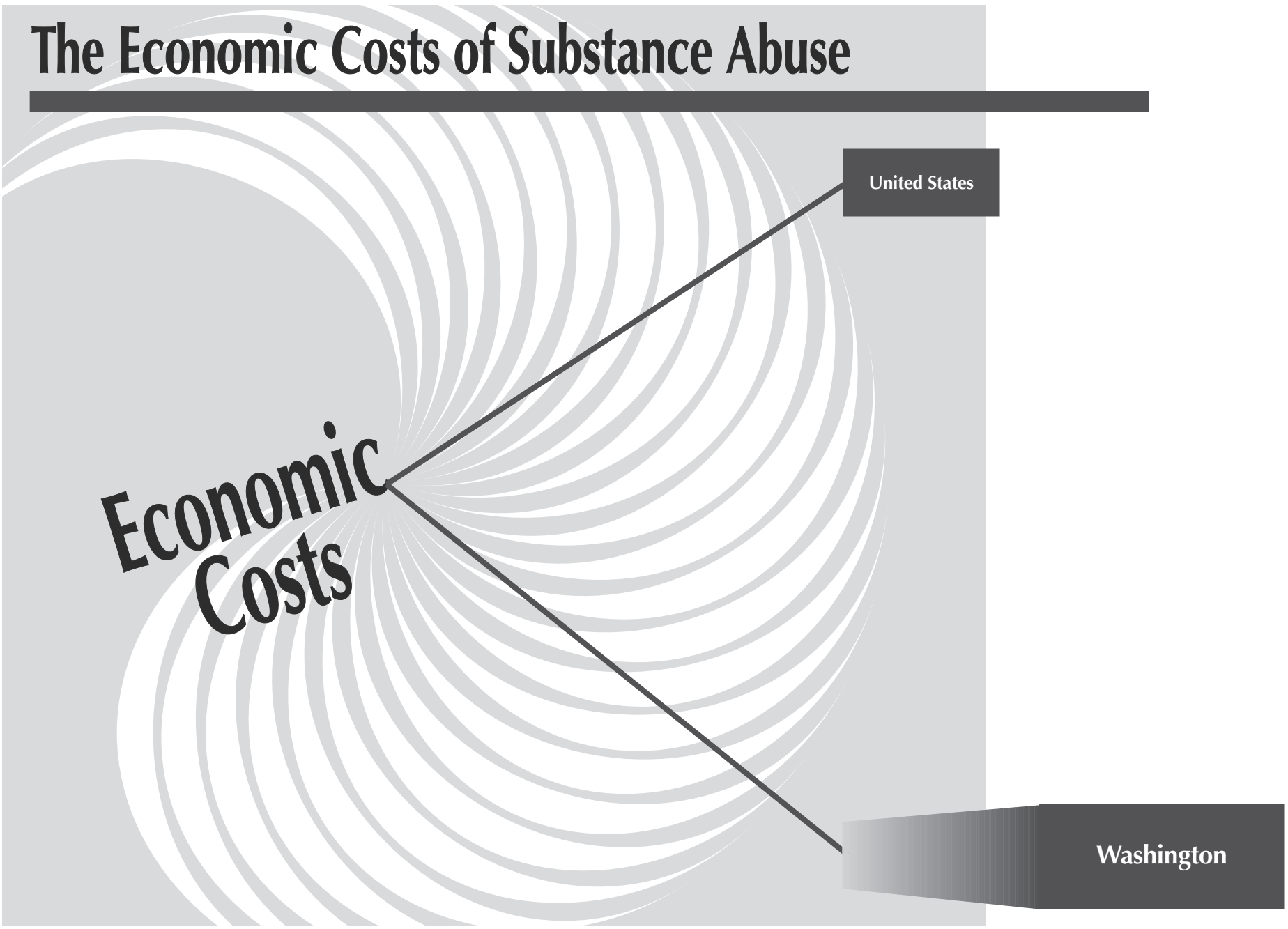

Source: Mark, T. et al., "U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001." *Health Affairs* – Web Exclusive, 2005.

A 2005 study published in the journal *Health Affairs* found that as a percentage of the total spent on health care in the United States, spending on substance abuse treatment fell from 1.6% in 1991 to 1.3% in 2001, representing a 14.5% decline.

Substance abuse treatment has been scientifically proven to produce cost offsets in decreased mortality, lower crime and criminal justice costs, higher worker productivity, less reliance on public assistance and other social services, fewer medical and psychiatric hospitalizations and emergency room visits, and lower health care costs. Despite this, chemical dependency treatment remains extremely underfunded at both the state and federal level. Of the $4,851 spent per person on health care in the U.S. in 2001, only $65 went for substance abuse treatment.[1]

[1] Mark, T. et al. "U.S. Spending for Mental Health and Substance Abuse Treatment, 1991-2001." *Health Affairs* – Web Exclusive, March 29, 2005.

# The Economic Costs of Substance Abuse



# The Economic Costs of Substance Abuse in Washington State

***A study commissioned by the Division of Alcohol and Substance Abuse estimated the total economic costs of alcohol and drug abuse in Washington State at $5.21 billion in 2005, a 105% increase over 1996. This represents $832 for every non-institutionalized resident in the state, an inflation-adjusted per capita increase of 47% over 1996.[1]***

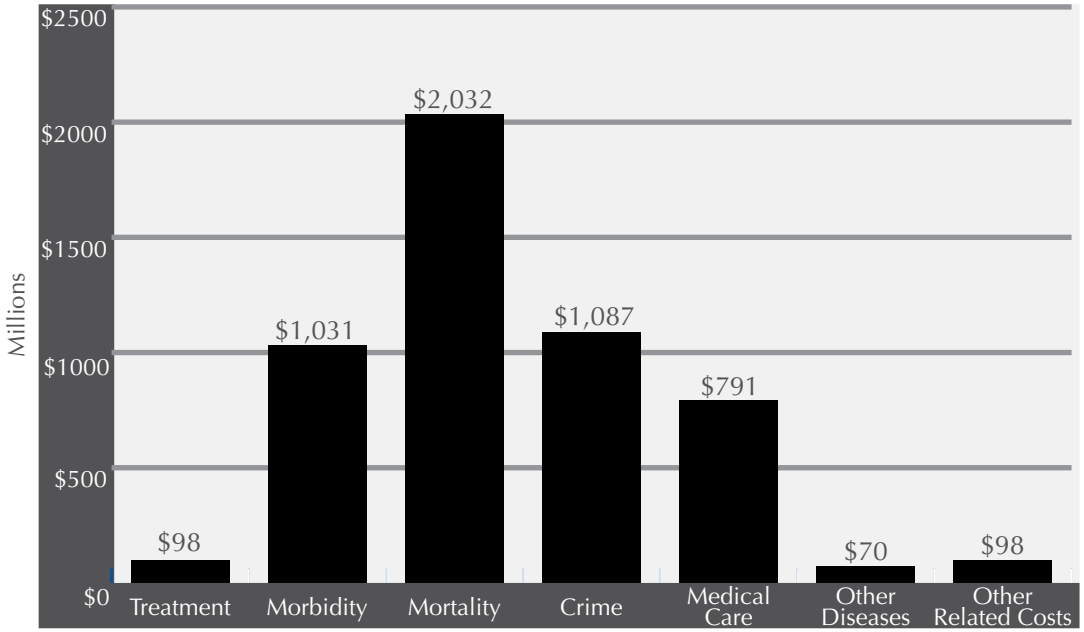
## *Among the study's key findings were:*

- *Alcohol abuse accounted for 56% of total economic costs; drug abuse for 44%.*
- *There were 3,244 deaths in Washington State in 2005 caused by or related to alcohol or drug abuse, representing approximately 89,000 years of potential life lost.*
- *Of the 3,244 deaths, 2,388 (74%) were alcohol-related, and 836 (26%) were drug-related.*
- *Leading causes of substance abuse-related deaths were accidental drug-related poisoning (677 deaths), alcohol-related cirrhosis and liver damage (437 deaths), and suicide (233 deaths).*
- *Of 154 arrests for homicide, 48 (31%) were alcohol-related, and 24 (16%) were drug-related.*
- *Of 5,128 arrests for felonious assault, 1,379 (27%) were alcohol-related, and 513 (10%) were drug-related.*
- *There were approximately 39,000 hospital discharges classified as alcohol- or drug-related, representing an increase of 140% since 1996. Total cost of treating these hospital cases was $377 million, of which $316 million (84%) resulted from diseases and injuries classified as alcohol-related.*
- *Total estimated alcohol- and drug-related crime costs in 2005 doubled from $541 million in 1996 to $1.087 billion in 2005.*

[1] Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State*, 2005. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

# Costs Related to Mortality, Crime, and Morbidity Represent the Largest Economic Costs of Drug and Alcohol Abuse.

***Economic Costs of Drug and Alcohol Abuse in Washington, 2005***




Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005*. Washington State Division of Alcohol and Substance Abuse, 2007.

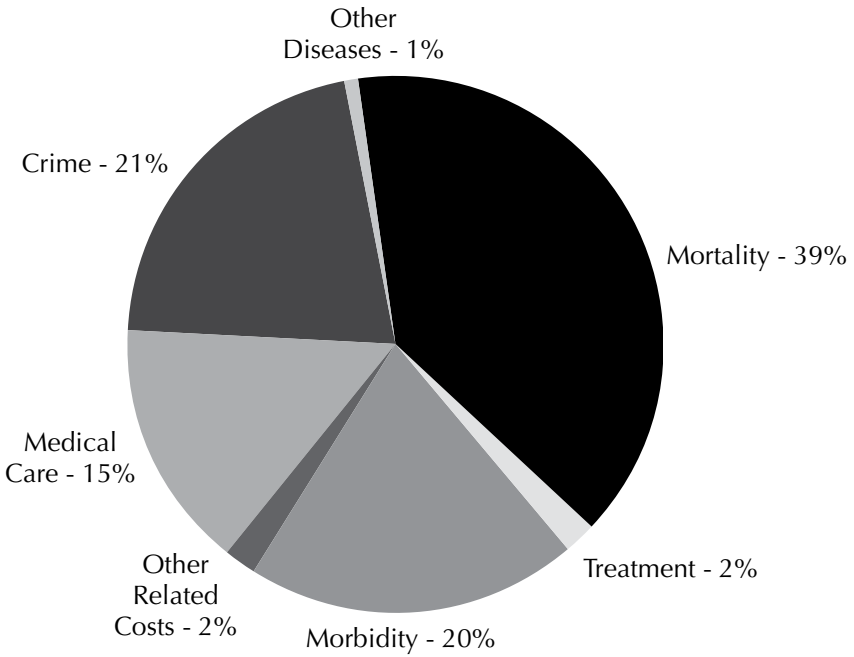
This graph indicates that mortality-, crime-, and morbidity-related costs represented the largest economic costs of substance abuse in 2005. The estimated cost per death measured in terms of lost income was $630,000. Medical care costs ($791 million) - including hospital, outpatient medical care, prescription drugs, nursing homes, and other professional costs - were almost four times what they were in 1996 ($211 million).[1]



[1] Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State*, 2005. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

# Treatment Represented Only 2% of the Total Economic Costs of Alcohol and Other Drug Abuse in 2005.

***Distribution of Drug and Alcohol-Related Costs***

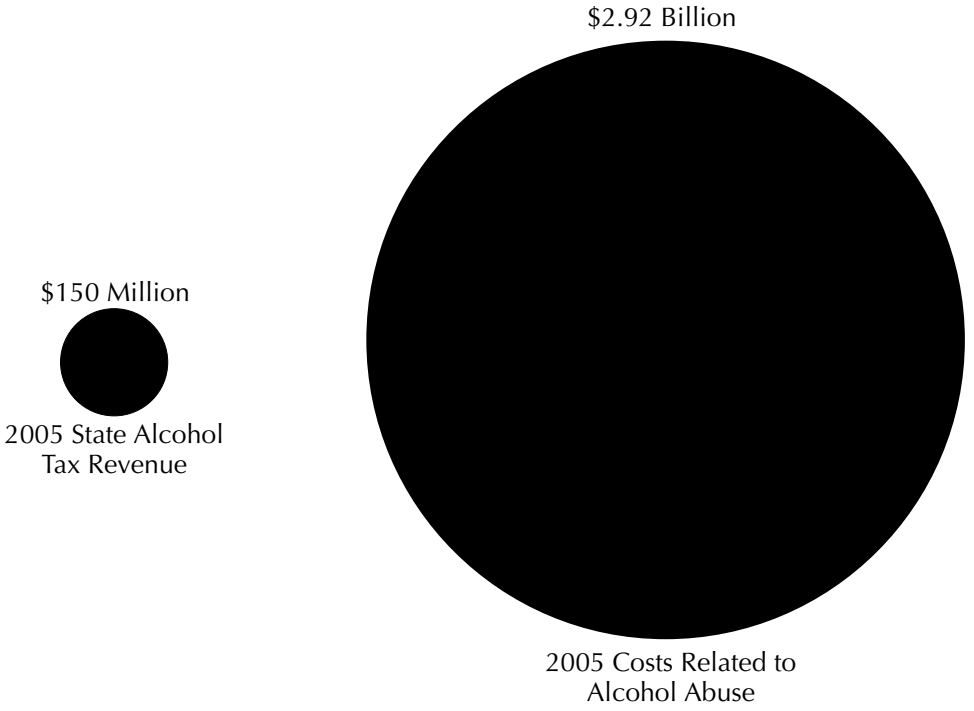



Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005*. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

This chart indicates that alcohol and drug treatment represents a very small fraction (2%) of the total economic costs of substance abuse in Washington State.[1] Yet, data — much of which is contained in this report — indicate that treatment can contribute significantly to lower morbidity and mortality, decreased crime, increased employment and higher worker productivity, reduced spread of infectious diseases, and lower medical costs. Alcohol and drug treatment continues to be a wise investment in the health and safety of communities, and the economic vitality of Washington State.

[1] Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005.* Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

# Costs Related to Alcohol Abuse in Washington State in 2005 were Approximately 20 Times Greater than Revenues Received from State Alcohol Taxes.




Source: Wickizer, T., *The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005*. Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

In fiscal year 2005, approximately $150 million was gathered through state alcohol taxes levied on beer, wine, and spirits. This is 53% more than the total ($98 million) spent by the state on alcohol and drug treatment combined.[1]



[1] Wickizer, T. *The Economic Costs of Drug and Alcohol Abuse in Washington State, 2005*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2007.

# Impacts of Substance Abuse on the Washington State Budget*

***A 2009 study conducted by the National Center on Addiction and Substance Abuse at Columbia University estimated 2005 state government spending related to substance abuse in Washington State at $3.2 billion. Less than 4% of that total was spent on prevention and treatment.***

## *Other key findings of the study included:*

- *Nationally, in 2005, $135.8 billion in state government spending was used to deal with tobacco, alcohol, and other drug misuse and addiction. This was 15.7% of total spending.*

- *If substance abuse and addiction were its own state budget category, it would rank second behind spending on elementary and secondary education (and ahead of Medicaid).*

- *For every $100 spent by state governments on substance abuse and addiction, the average spent on prevention, treatment, and research was $2.38.*

- *For every dollar the federal and state governments spent on prevention and treatment, they spent $59.83 "shoveling up the consequences" in additional crime and criminal justice, health care, education, and social service costs.*

- *In 2005, local governments spent $93.8 billion on substance abuse and addiction (9% of their budgets), outstripping local spending for transportation and public welfare.*[1]

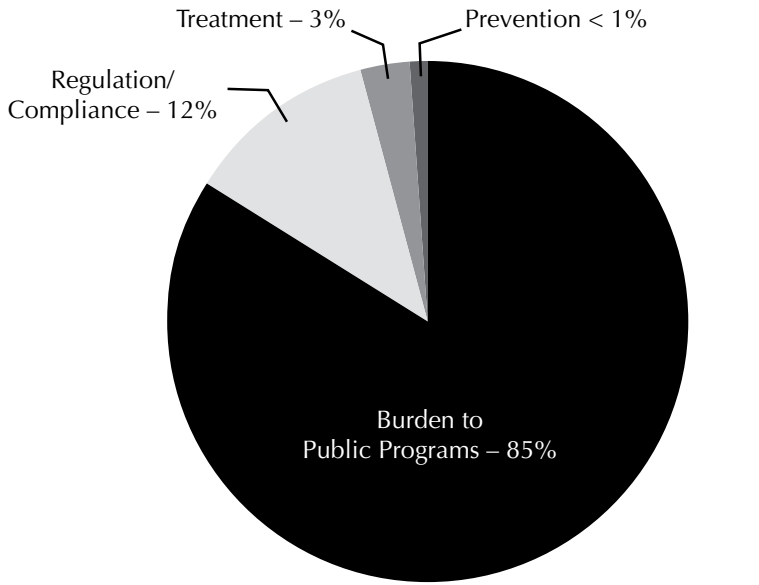
*Includes tobacco, alcohol, and other drug abuse-related spending.

[1] National Center on Addiction and Substance Abuse at Columbia University. (CASA), *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets.* New York, NY: CASA, May 2009.

NEW/CHANGING TREND

# In 2005, Washington State Spent $3.2 Billion on Services Related to Substance Abuse and Its Impacts.*

***Distribution of State Spending Related to Impacts of Substance Abuse***




Source: National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets,* 2009.

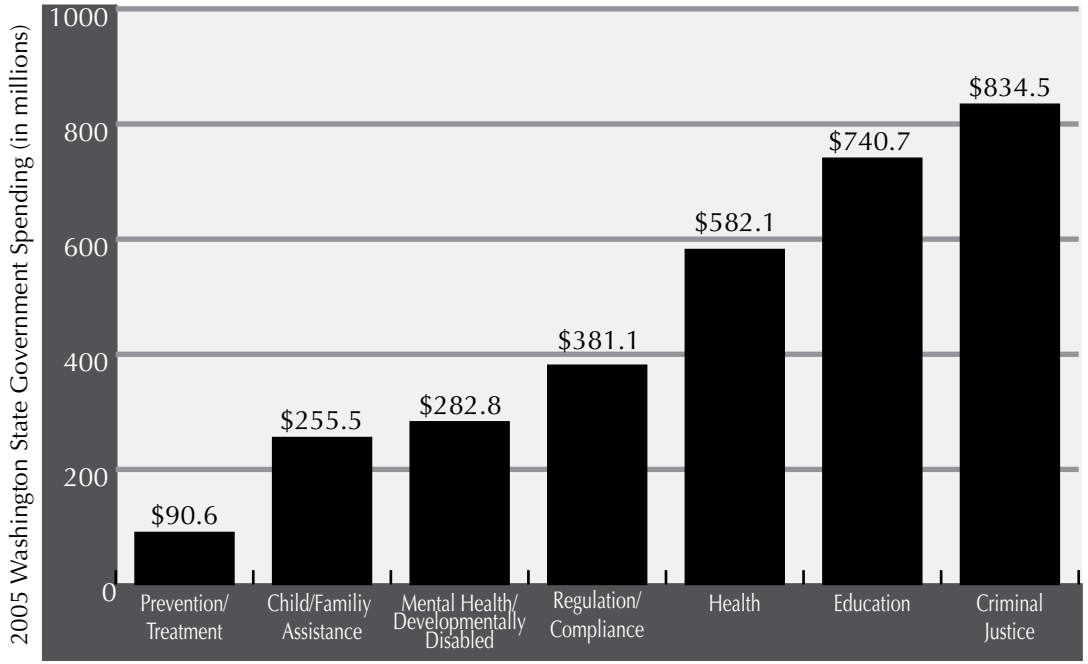
In 2005, Washington State spent $3.2 billion on services related to tobacco, alcohol, and other drug misuse and addiction. The majority went to deal with the consequences of abuse and addiction, in health care, crime and criminal justice, social services, mental health, and education costs, with much smaller amounts spent on prevention and treatment. Aggregated together, state spending related to substance abuse and its impacts would be the second largest item in the state budget, with only elementary and secondary education spending being greater.

*Includes tobacco, alcohol, and other drug misuse.



National Center on Addiction and Substance Abuse at Columbia University (CASA). *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets.* New York, NY: CASA, May 2009.

# Substance Abuse Results in Significantly Higher State Government Spending on Education, Criminal Justice, and Health.



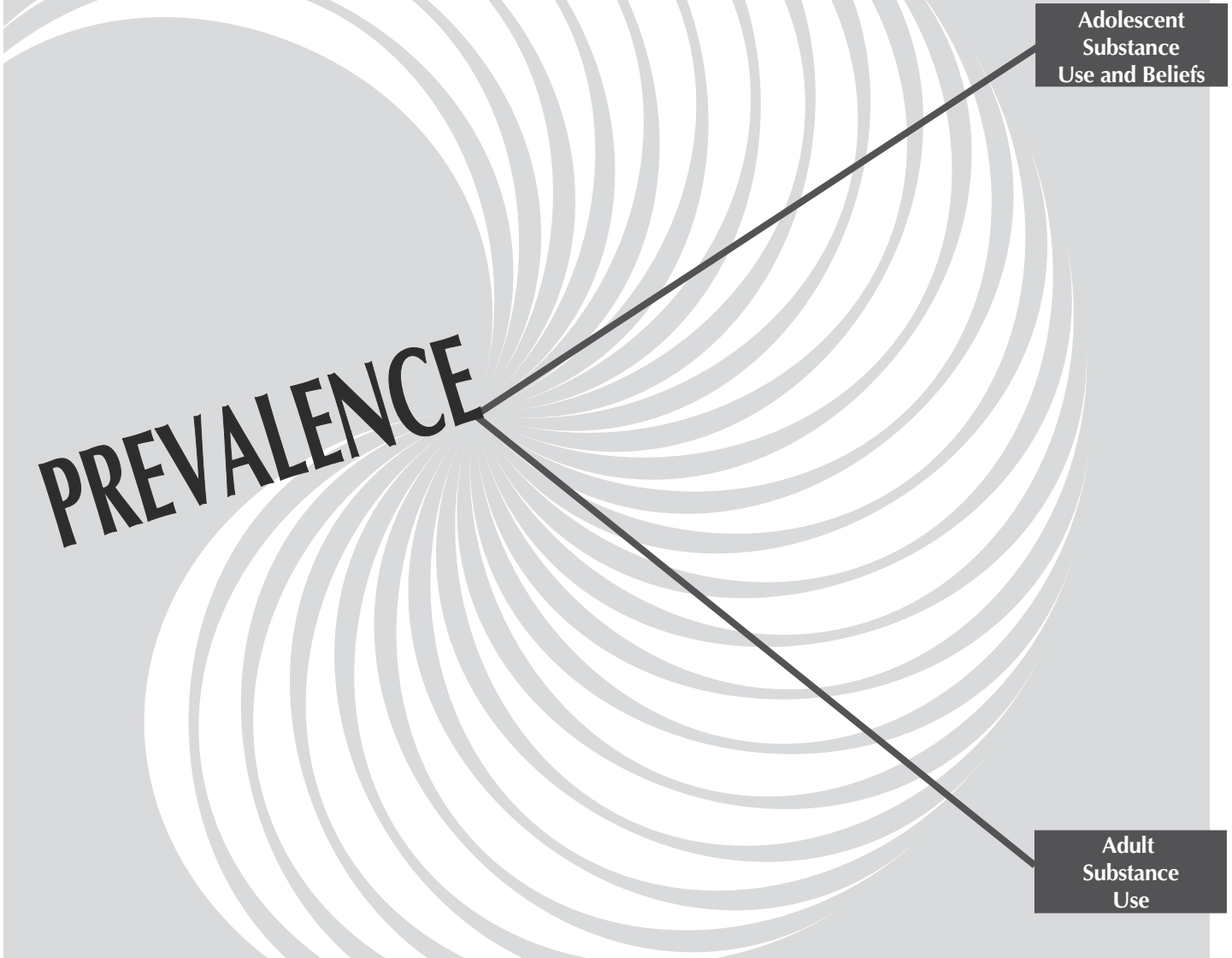

Source: National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets,* 2009.

In 2005, 15.4% of Washington State government spending, or $422 for every resident, was related to tobacco, alcohol, or other drug abuse or addiction. Less than $6 of this amount was spent on prevention and treatment.[1]

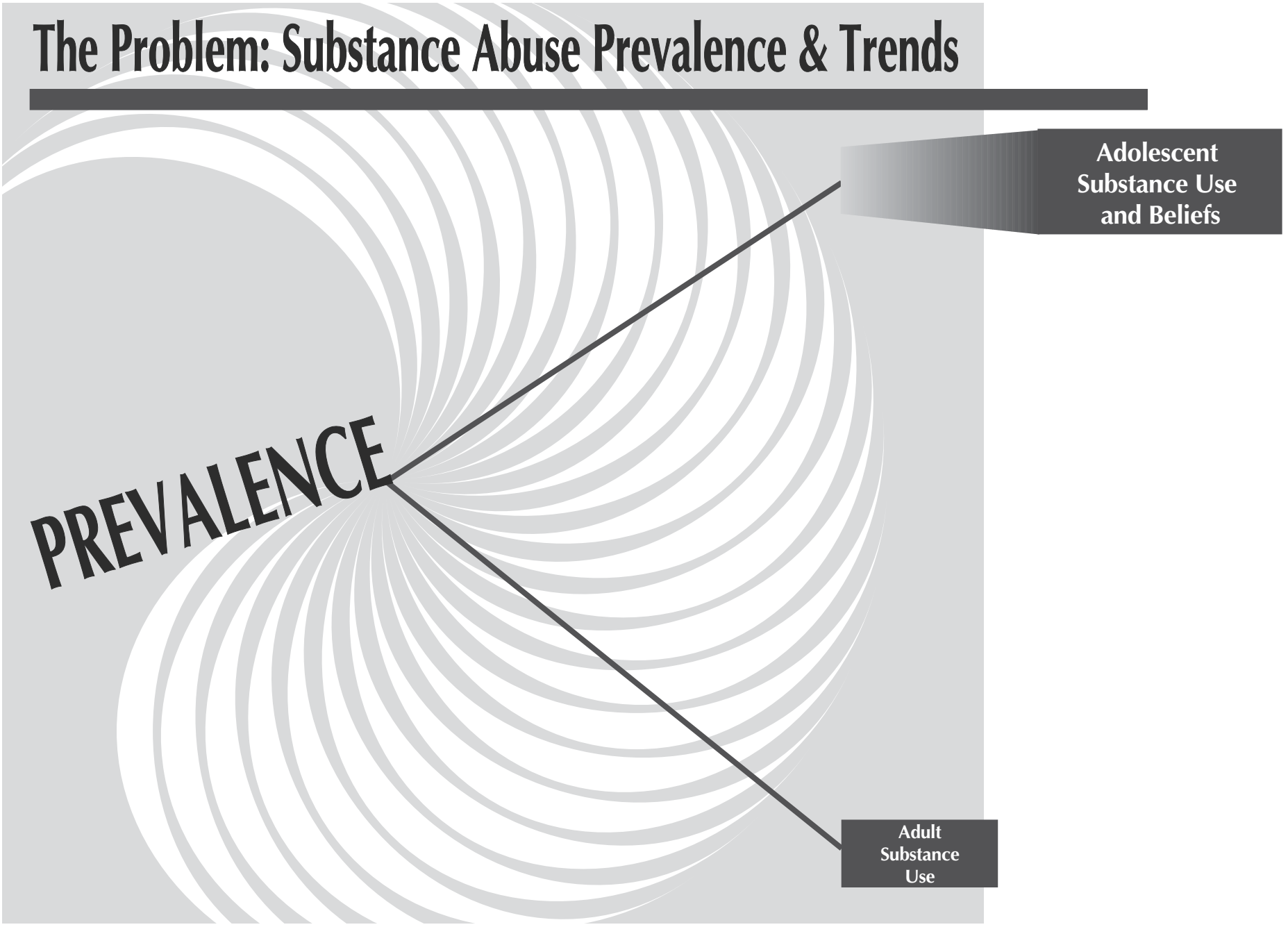


National Center on Addiction and Substance Abuse at Columbia University. *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets.* New York, NY: CASA, May 2009.

# The Problem: Substance Abuse Prevalence & Trends



# The Problem: Substance Abuse Prevalence & Trends



# Washington's Healthy Youth Survey

In Washington State, multiple state agencies have been conducting surveys of youth health behavior since 1988. The surveys have been based on two different national surveys: Monitoring the Future supported by the National Institute on Drug Abuse; and the federal Centers for Disease Control and Prevention's Youth Risk Behavior Survey. In 1995, a Communities That Care survey, developed by the University of Washington, became an important component of the survey effort, integrating risk and protective factors. More recently, a Youth Tobacco Survey was incorporated.

To better coordinate these survey efforts, and to prevent the need for survey data from becoming an undue burden on schools, interested state agencies – Office of Superintendent of Public Instruction; Department of Social and Health Services' Division of Alcohol and Substance Abuse; Department of Health's Tobacco Control Program and Maternal and Child Health Program; Department of Community, Trade & Economic Development, Community Mobilization; and the Family Policy Council – resolved to cooperate on the administration of a single survey of youth behaviors every two years, to be administered in the fall. In 2008, the Liquor Control Board joined the coalition of agencies that support the single survey.

**The goals of this collaborative effort are:**

- To describe youth health behavior, habits, risks, and outcomes.
- To describe school, community, family, and peer/individual risk and protective factors.

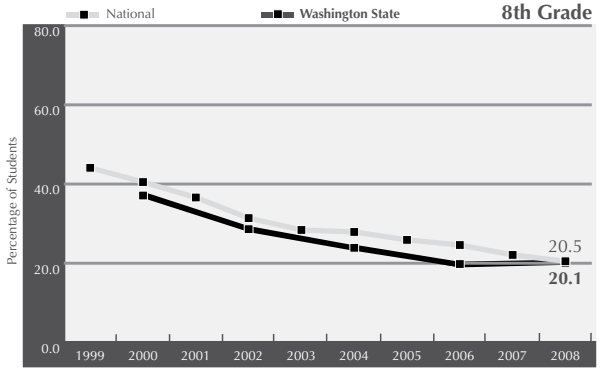
**To achieve these goals, it was agreed that the survey must:**

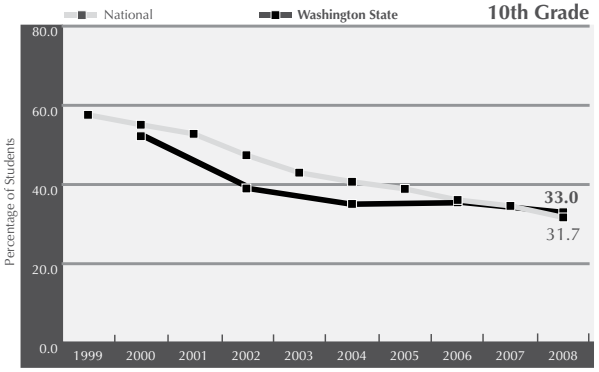
- Gather state-level data in a consistent manner (with predictable timing and using comparable measures over time).
- Support local-level data collection and use of data for planning, assessment, and evaluation of programs that serve youth.

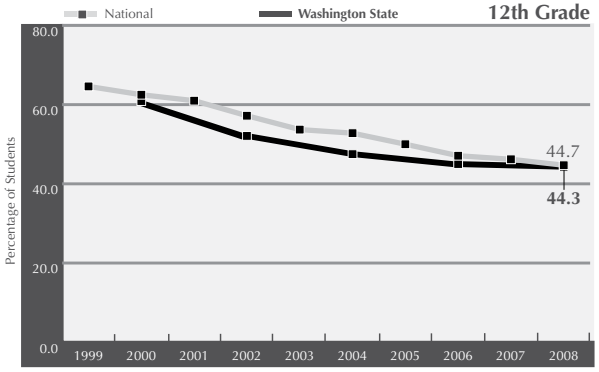
The 2008 Healthy Youth Survey reports data collected from more than 211,000 youth in grades, 6, 8, 10 and 12. The data presented on the following pages are from a random sample of the schools those youth attend. Not all youth are represented. Almost all of the schools are public schools, and include only a few alternative schools. In addition, many youth, especially in the 12$^{th}$ grade, are taking classes in Running Start, or are out of school for other reasons. Nevertheless, this survey reports on the vast majority of Washington's youth.

More information about the survey, as well as copies of the surveys and earlier state reports, can be found at www.hys.wa.gov. A new website, www.AskHYS.net, allows users to download reports on particular topics, and to build queries using individual questions.

# The Percentage of Students, Both in Washington and Nationally, Who Have Ever Tried Smoking is Declining.*




Tobacco use is the leading cause of preventable disease, disability, and death in the United States. Each year, an estimated 443,000 people die prematurely from smoking or exposure to secondhand smoke, and another 8.6 million have a serious illness caused by smoking.[1]

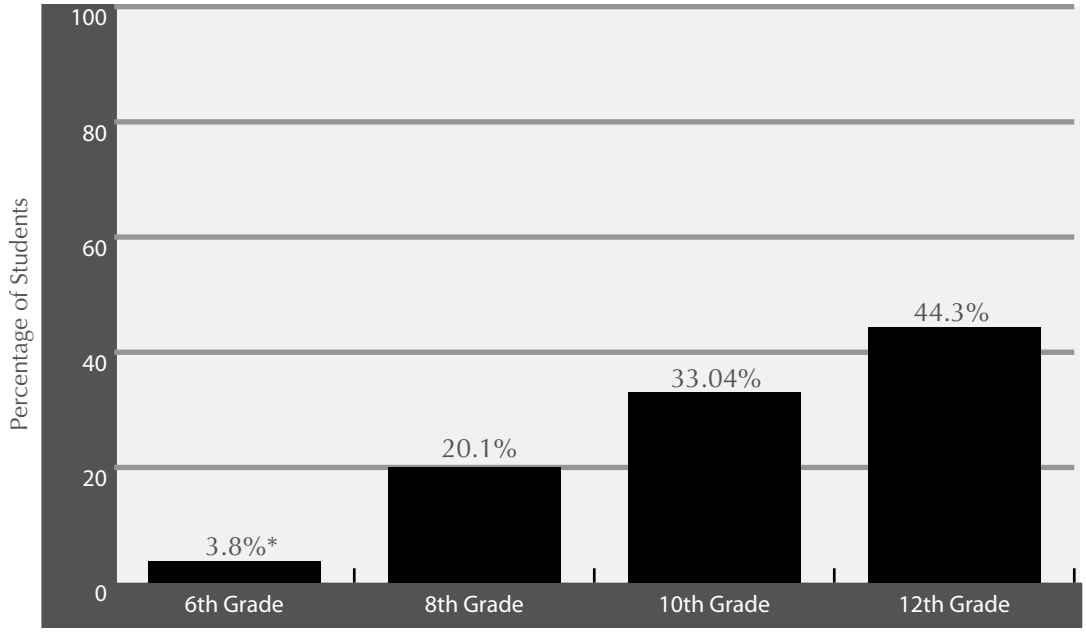
These graphs indicate that experimentation with tobacco is on the decline, both in Washington State and nationally. The state target is to raise the average age of adolescents' first use of tobacco to 16. Some 45 Washington youth start smoking every day.[2]

[1]National Center for Chronic Disease Prevention and Health Promotion. *Tobacco Use: Targeting the Nation's Leading Killer – At a Glance 2009.* Atlanta, GA: Centers for Disease Control and Prevention, 2009.
[2] Tobacco Prevention and Control Program. *Progress Report – March 2009.* Olympia, WA: Washington State Department of Health, 2009.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

Source: National data from the National Institute on Drug Abuse, *Monitoring the Future.* State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey.*

# By 12th Grade, Almost Half of Washington Adolescents Have Tried Smoking.




Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008*.

The percentage of Washington State students who have experimented with smoking is declining. Use of smokeless tobacco, on the other hand, has seen slightly increases in the last several *Healthy Youth Surveys.*

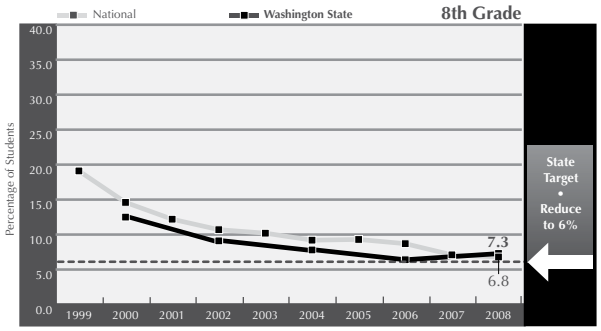
Research indicates that increasing taxes on cigarettes, when combined with anti-smoking campaigns, is one of the most cost-effective strategies to prevent tobacco initiation among youth. It has been estimated that for every 10% increase in the price of cigarettes, there is a corresponding 6-7% decline in the number of youth who smoke.[1] However, it should be noted that the *Healthy Youth Survey* found that only 15% of 10th grade youth reported they usually obtained tobacco by purchasing it themselves.[2]

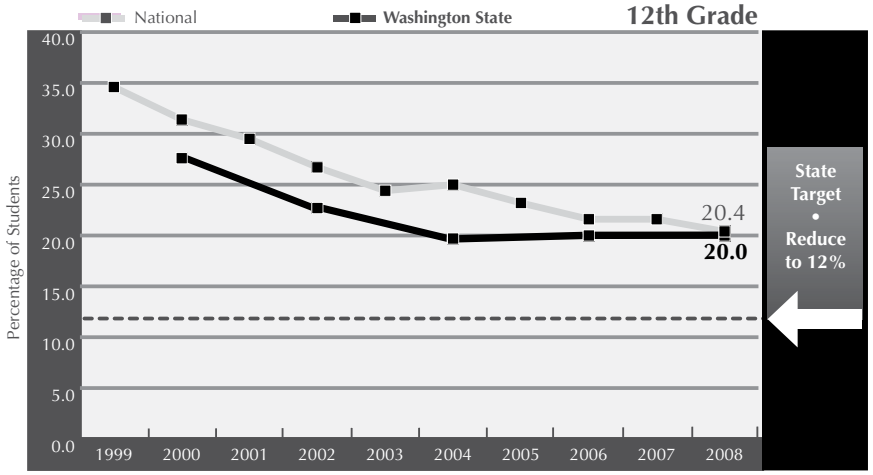
**6th grade percentage is for students smoking a whole cigarette; 8th, 10th, and 12th grade data are for students trying smoking, "even just a puff".*

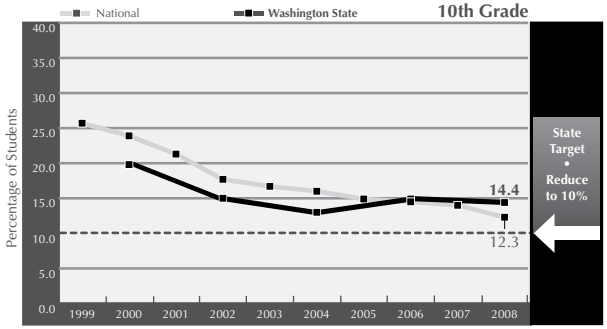
[1] Tauras, J. *"Public Policy and Smoking Cessation Among Young Adults in the United States," Health Policy* 6, 2004; Emery, S., et al. "Does Cigarette Price Influence Adolescent Experimentation?" *Journal of Health Economics* 20, 2001.
[2] Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board. *Healthy Youth Survey – 2008*. Olympia, WA: 2009.

# After Waning for a Decade, in 2008 the Percentage of Washington State 8th, 10th, and 12th Graders Who Smoked in the Past 30 Days was No Longer Declining.

Declines in smoking by youth in Washington State and nationally have leveled off. Since the inception of the Washington State Tobacco Prevention and Control Program, youth smoking has dropped 70% among 6th graders, 52% among 8th graders, 42% among 10th graders, and 43% among 12th graders. There are now about 65,000 fewer youth smokers in Washington, which will result in 13,000 youth being spared an early tobacco-related death.[1]




Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey*.

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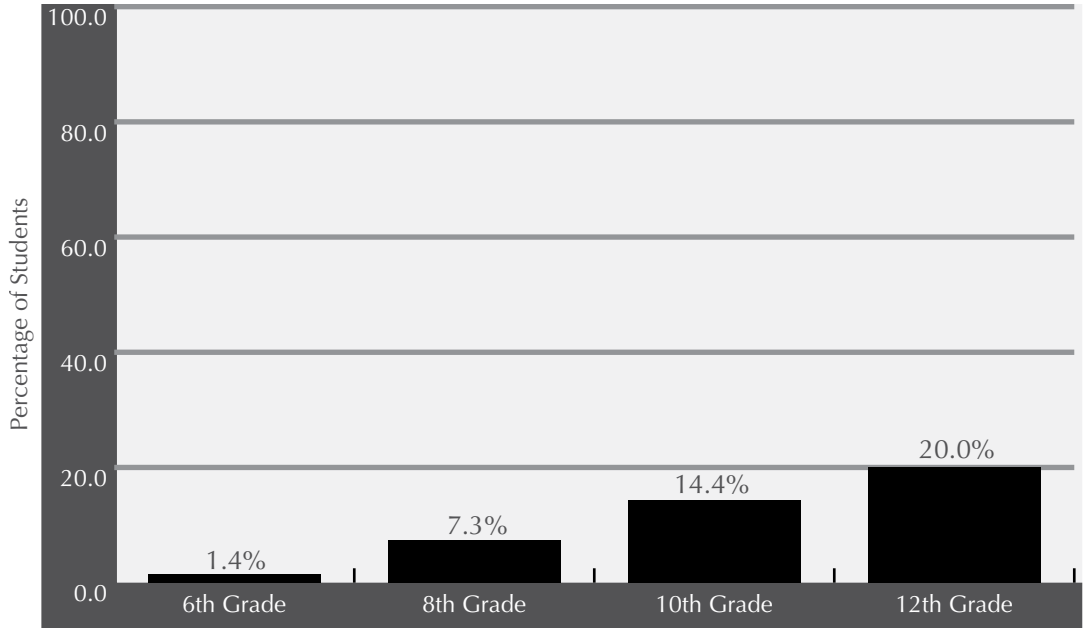
[1]Tobacco Prevention and Control Program. *Progress Report – March 2009*. Olympia, WA: Washington State Department of Health, 2009.

# A Fifth of Washington High School Seniors Report Having Smoked a Cigarette in the Past 30 Days.

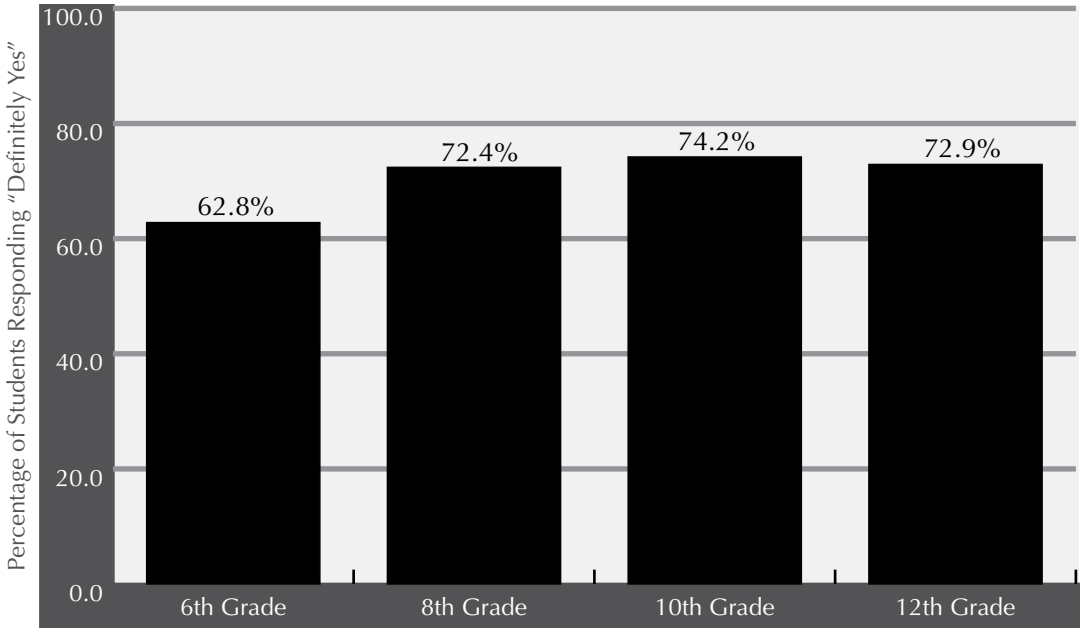



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008.*

Among young people, short-term health consequences of smoking include respiratory and non-respiratory effects, nicotine addiction, and the associated risk of other drug use. Long-term health consequences of youth smoking are reinforced by the fact that most young people who begin to smoke regularly in their youth continue to do so as adults.[1] In 2008, 49% of Washington State 12th graders who smoke reported that they tried to quit.[2]

[1] U.S. Surgeon General. *Tobacco Use Among Young People – A Report of the Surgeon General.* Washington, DC: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1994.
[2] Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board. *Healthy Youth Survey – 2008.* Olympia, WA: 2009.

# In 2008, Most Washington State Students Believed that Young People Definitely Risk Harming Themselves by Smoking 1-5 Cigarettes Per Day.



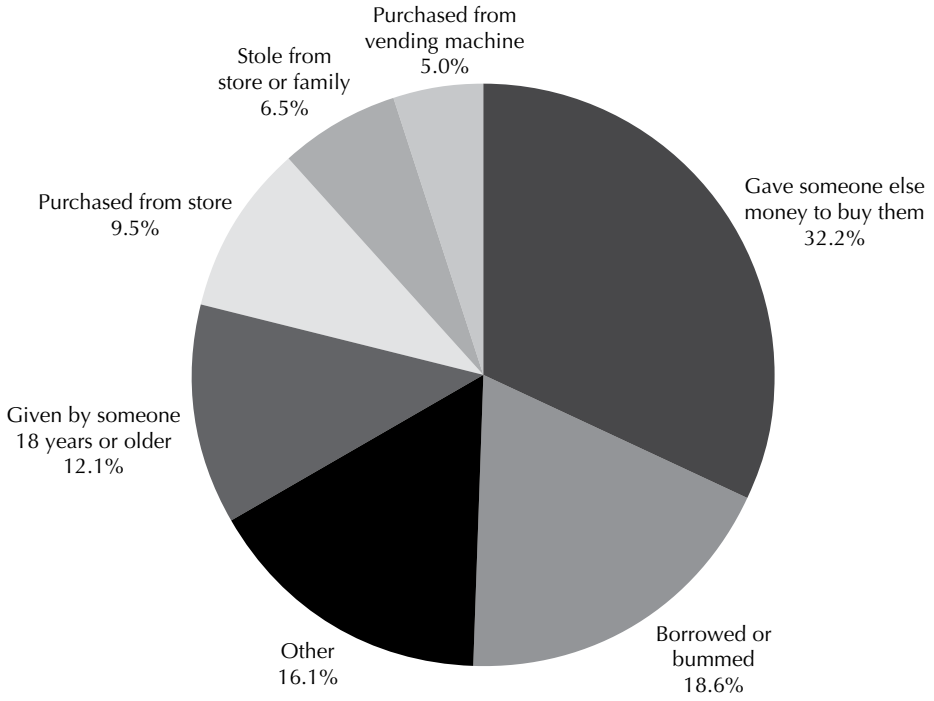

Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008*.

Most Washington State students perceive a high degree of risk from smoking cigarettes. Nonetheless, the rate of smoking among students increases as they get older. This suggests that expanded efforts need to be focused on helping current young smokers quit. In 2008, 44% of Washington State 10th graders and 49% of Washington State 12th graders who smoke reported that they tried to quit. It appears that approximately one-third may have been successful, reporting no recent (past-30-day) tobacco use.[1]



[1] Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board. *Healthy Youth Survey – 2008*. Olympia, WA: 2009.

# Most 10th Grade Smokers in Washington State Obtain Cigarettes from Others.



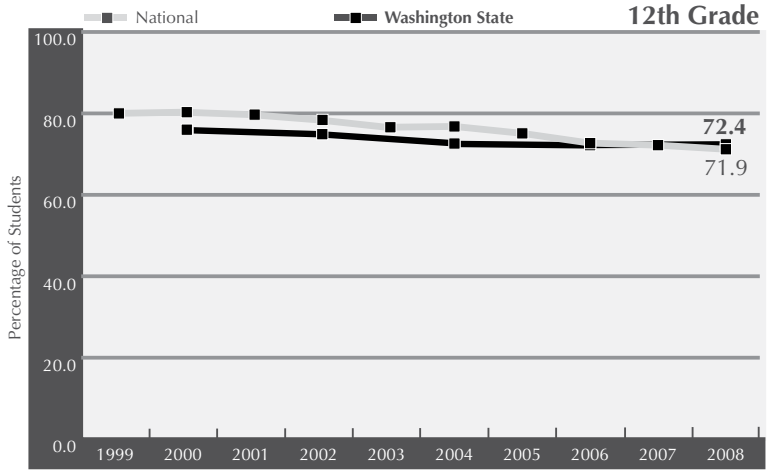

Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008*.

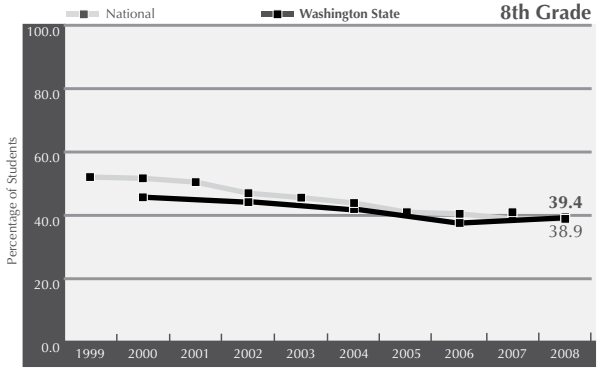
Only 14.5% of Washington State 10th grade smokers obtain cigarettes by purchasing them. Almost 85% of 10th graders obtain them through others. This suggests that there is a culture around smoking that still makes it socially acceptable for others to participate in young people developing a highly dangerous health habit. About 70,000 Washington youth still smoke, and 45 youth start smoking daily.[1]

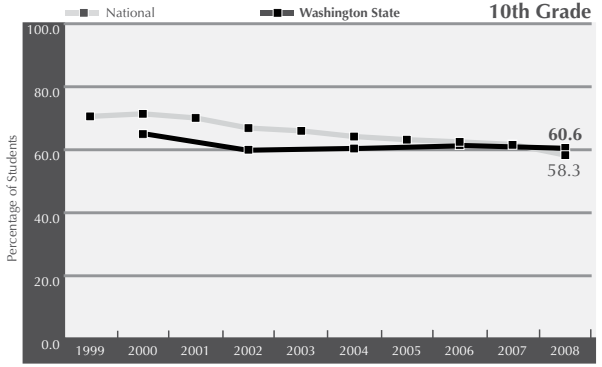
[1] Tobacco Prevention and Control Program. *Progress Report – March 2009.* Olympia, WA: Washington State Department of Health, 2009.

# The Percentage of Students, Both in Washington and Nationally, Who Have Tried Alcohol is Relatively Constant.*

In 2001, underage drinkers (ages 12-20) consumed 17.5% of alcohol consumed in the United States, accounting for $22.5 billion in total alcohol sales. Youth who start drinking at age 14 or younger are four times more likely to become alcohol dependent in their lifetimes than those who start drinking at age 20 or older.[1] The state target is to raise the average age of adolescents' first use of alcohol to 16.




Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey*.

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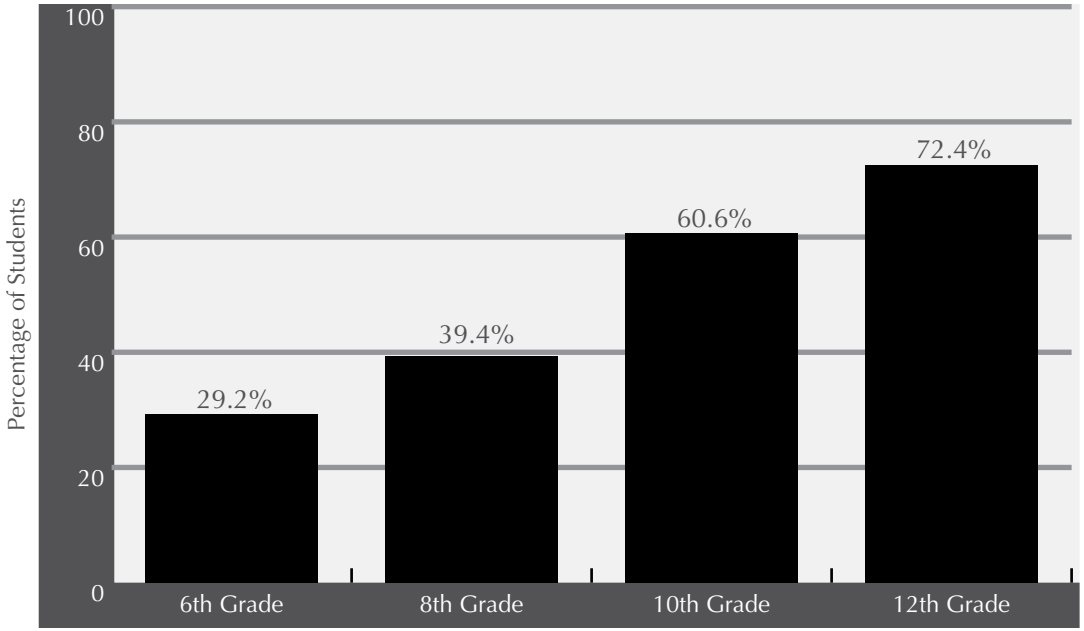
[1] Foster, S., et al. "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.

# Almost a Third of Washington 6th Graders Have Tried Alcohol.




Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008*.

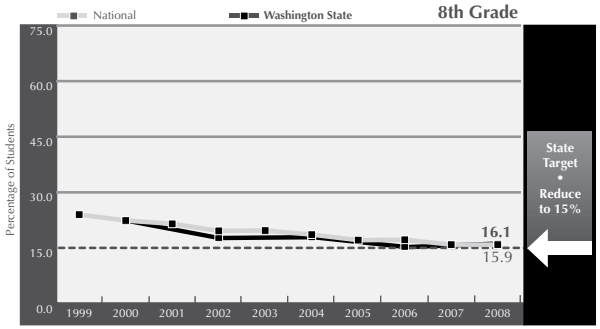
Teenage drinking can physically damage the brain; interfere with mental and social development; interrupt academic progress; increase chances of risky sexual behavior and teen pregnancy, juvenile delinquency, and crime; compromise health; and result in unintended injury and death.[1]

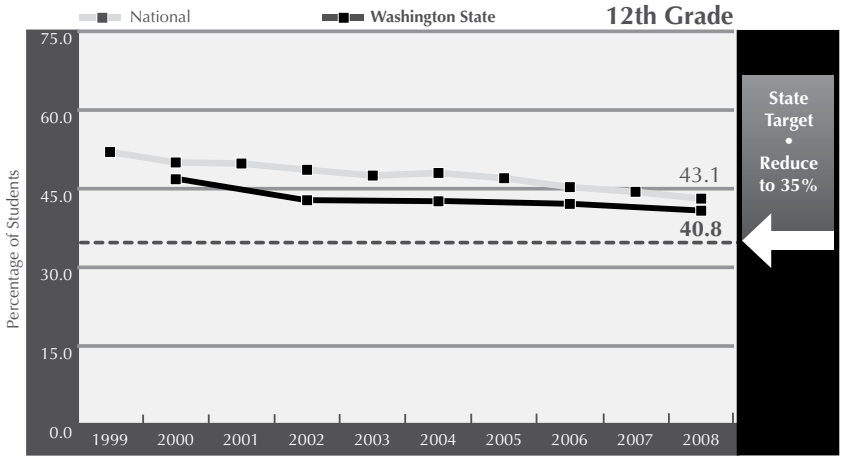
Almost half of Washington students have tried alcohol before they reach high school. Children who begin experimenting with and/or using alcohol at or before 7th grade are significantly more likely at age 23 to be alcohol dependent; use marijuana weekly; sell marijuana; commit felonies; and be arrested.[2] A recent study found that youth who witness or experience abuse as a child (witness domestic violence, experience physical abuse, experience sexual abuse) before age 10 are significantly more likely to drink before age 13.[3]

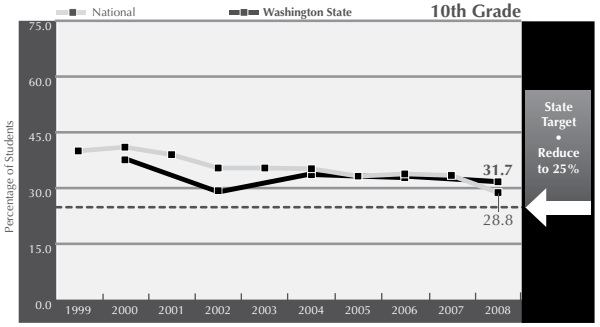
[1] Foster, S., et al. "Alcohol Consumption and Expenditures for Underage Drinking and Adult Excessive Drinking," *Journal of the American Medical Association* 289(8), February 26, 2003.
[2] Ellickson, P., Tucker, J., and Klein, D. "Ten-Year Prospective Study of Public Health Problems Associated with Early Drinking," *Pediatrics* 111(5), 2003.
[3] Hamburger, M., et al. "Childhood Maltreatment and Early Alcohol Use Among High-Risk Adolescents." *Journal of Studies of Alcohol and Drugs* 69(2), 2008.

# Use of Alcohol in the Past 30 Days by Washington State 8th, 10th and 12th Graders Has Leveled Off.*

Rates of recent alcohol use among youth appears to have leveled off nationally and in Washington State. Research indicates that initiation of alcohol use at an early age increases the risk that teenagers will become heavier drinkers as adults, with alcohol-related problems later in life.[1] The Institute of Medicine of the National Academy of Sciences recommends that Congress and state legislatures should raise alcohol excise taxes as a proven method to curb underage drinking.[2]




Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey*.

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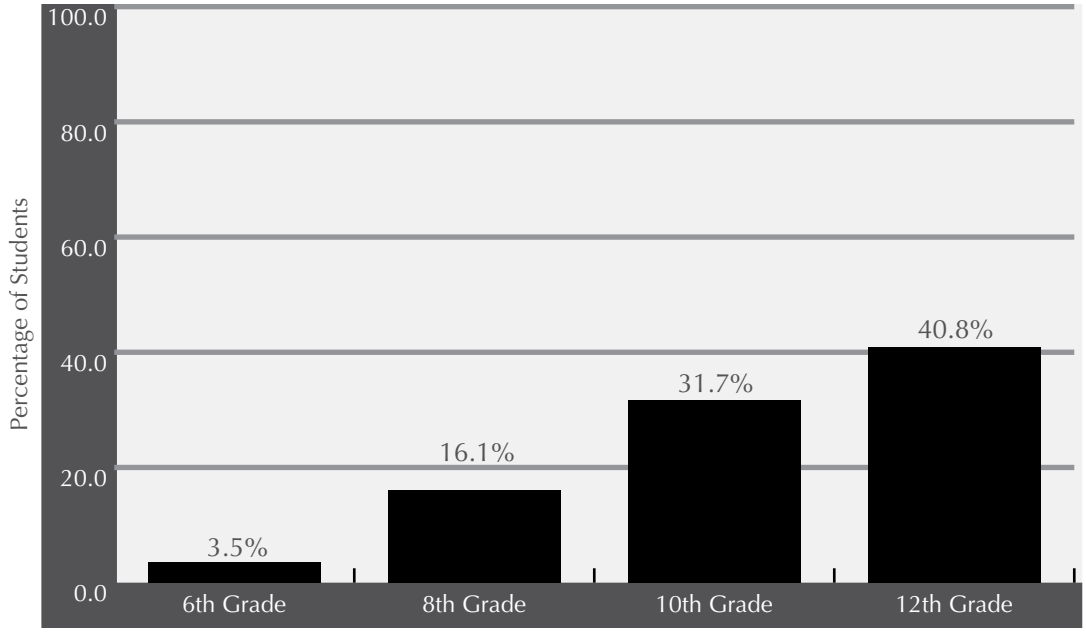
[1] Dewit, D., et al. "Age at First Alcohol Use: A Risk Factor for the Development of Alcohol Disorders," *American Journal of Psychiatry* 157, 2000; Grant, B., and Dawson, D. "Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey," *Journal of Substance Abuse* 9, 1997.
[2] Bonnie, R., and O'Connell, M., eds. *Reducing Underage Drinking: A Collective Responsibility*. Washington, DC: National Academy of Sciences, Institute of Medicine, National Research Council, 2004.

# One Out of Six Washington 8th Graders Report Having Used Alcohol in the Past 30 Days.



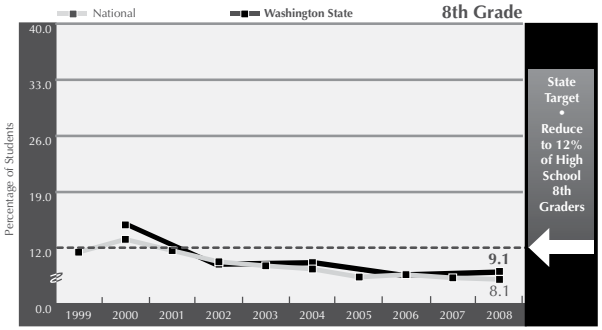

Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008*.

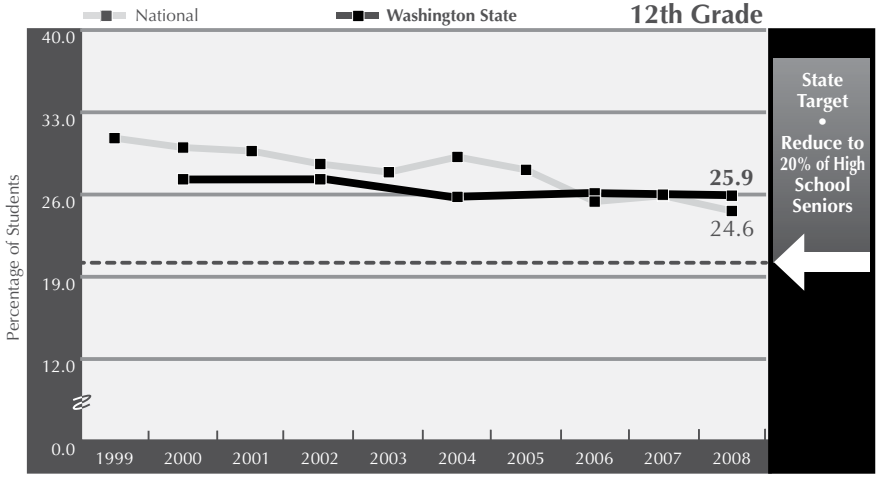
A recent study indicates that youth ages 12-20 are responsible for 17.5% of all alcohol consumed in the United States.[1] Despite the fact that it is illegal, more than 40% of Washington high school seniors report using alcohol in the past 30 days. Teenage drinking is associated with a full range of academic, social, and medical consequences, including juvenile delinquency and crime, risky sexual behavior and teen pregnancy, poor academic progress and school dropout rates, and unintentional injuries and death.[2] A 2009 meta-analysis of 112 studies indicates that alcohol consumption, including consumption among teens, is sensitive to the price of, and tax levels on alcohol.[3]

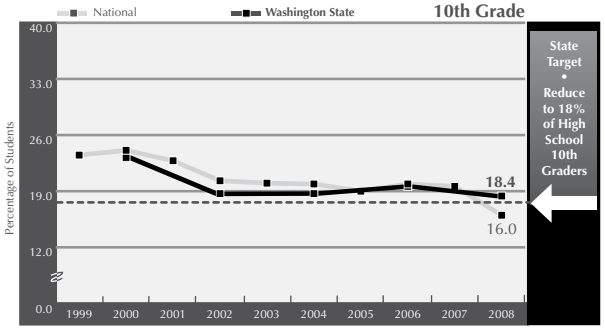
[1] Foster, S., et al. "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry". *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.
[2] *Ibid*.
[3] Wagenaar, A., et al. "Effects of Beverage Alcohol Price and Tax Levels on Drinking: A Meta-Analysis of 1003 Estimates from 112 Studies". *Addiction* 104, 2009.

# Recent Binge Drinking by Washington State 10th and 12th Graders Has Been Relatively Constant Since 2002.*

Recent binge drinking among Washington State 10th and 12th grade students has not changed significantly since 2002. Recent binge drinking is defined as having five or more drinks in a row on at least one occasion in the past two weeks. Youth who begin binge drinking at an early age are much more likely to continue as binge drinkers as adults.[1] A 2009 survey conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) found that 65% of all teens and 85% of 17-year-olds who were past-month drinkers report that they get drunk at least once in a typical month.[2]




Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey*.

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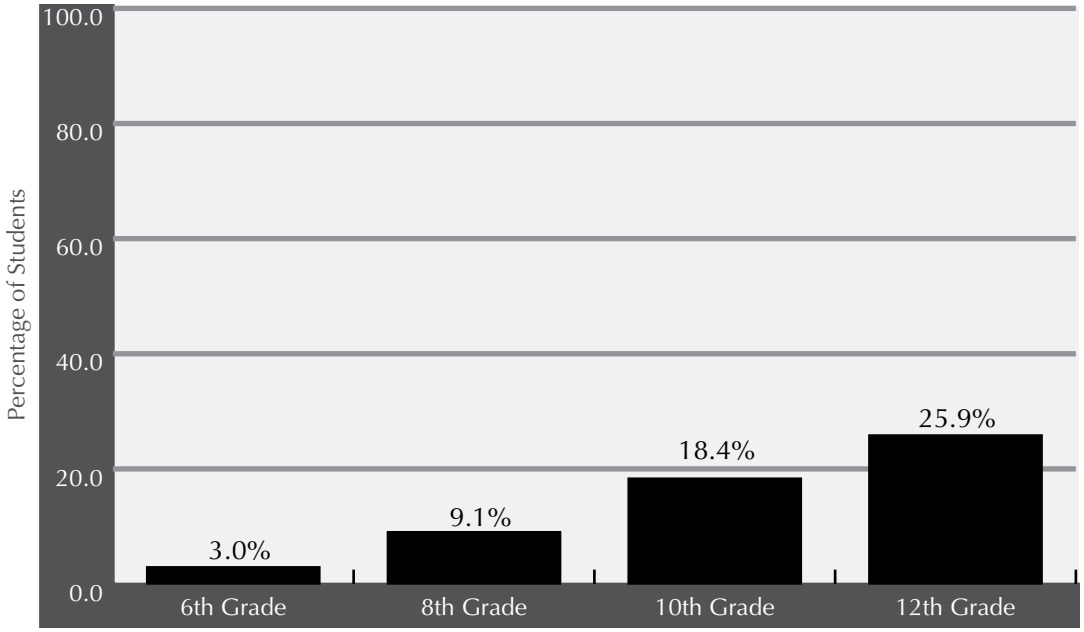
[1] McCarty, C., et. al. "Continuity of Binge and Harmful Drinking from Late Adolescence to Early Adulthood." *Pediatrics* 114(3), 2004.
[2] National Center on Addiction and Substance Abuse at Columbia University (CASA). *National Survey of American Attitudes on Substance Abuse XIV: Teens and Parents*. New York, NY: CASA, August 2009.

# More Than a Quarter of Washington Seniors Have Engaged in Recent Binge Drinking.




Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008*.

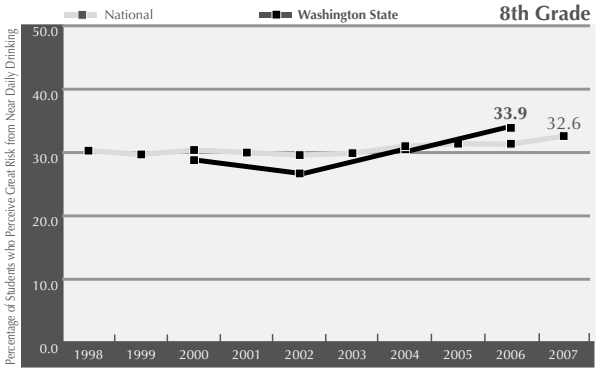
Recent binge drinking is defined as consuming five or more drinks in a row on at least one occasion in the past two weeks. A 2000 survey of Washington students indicates that binge drinking may start as early as the 6th grade, or earlier. Binge and heavy drinking among youth has been linked to motor vehicle crashes and deaths, physical fights, property destruction, poor school and employment performance, and involvement with law enforcement and the legal system, as well as impaired brain development and poor motor skills, and future adult alcoholism.[1]

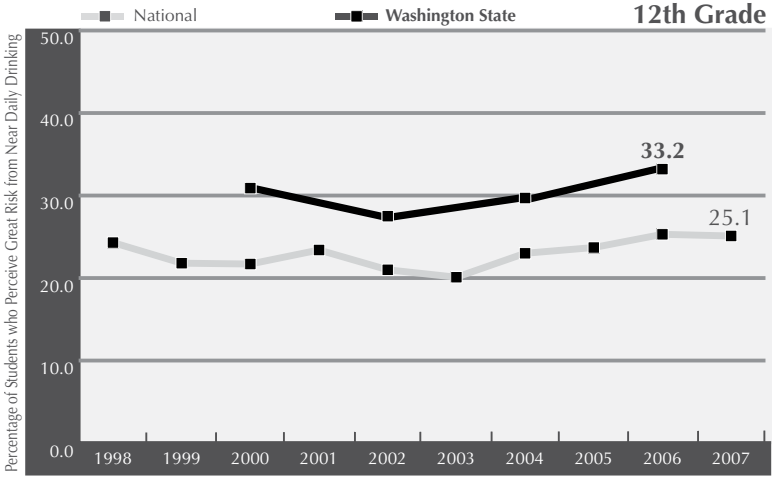
Evidence-based strategies for reducing youth binge drinking include changing social and community norms, improving law enforcement, reducing alcohol availability, and changing policies, including increasing excise taxes on alcohol.[2]

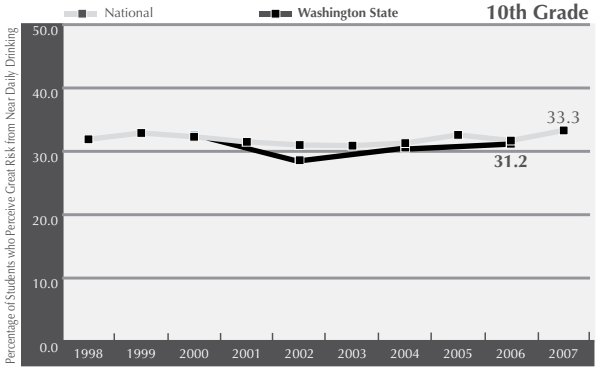
[1]Hoover, S. "Binge Drinking: Policy Strategies to Reduce Underage and Binge Drinking." *Prevention Tactics*, August 2008. Folsom, CA: Center for Applied Research Solutions, Community Prevention Initiative, 2008.
[2]Winters, K., and Mitchell, T. "Under Construction: Adolescent Brain Development and Its Implications for Preventing Alcohol and Drug Abuse." *Prevention Tactics* 8(8), 2005; Bonnie, R., and O'Connell, M., eds. *Reducing Underage Drinking: A Collective Responsibility*. Washington, DC: National Academy of Sciences, Institute of Medicine, National Research Council, 2004

# Only One-Third of Washington State 8th, 10th, and 12th Graders Perceive Great Risk from Drinking 1-2 Alcohol Drinks Nearly Every Day.*

These graphs indicate that approximately 70% of Washington 8th, 10th, and 12th grade students do not perceive great risk in near-daily alcohol consumption. National data indicate that student perception of risk regarding both regular use of alcohol and heavy drinking is relatively low, perhaps suggesting a high degree of acceptability of alcohol consumption among students.




Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey.*

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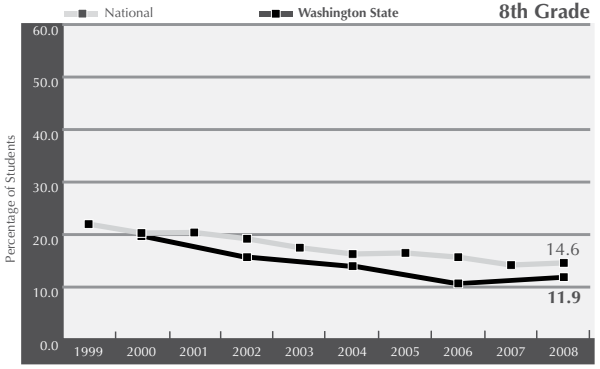
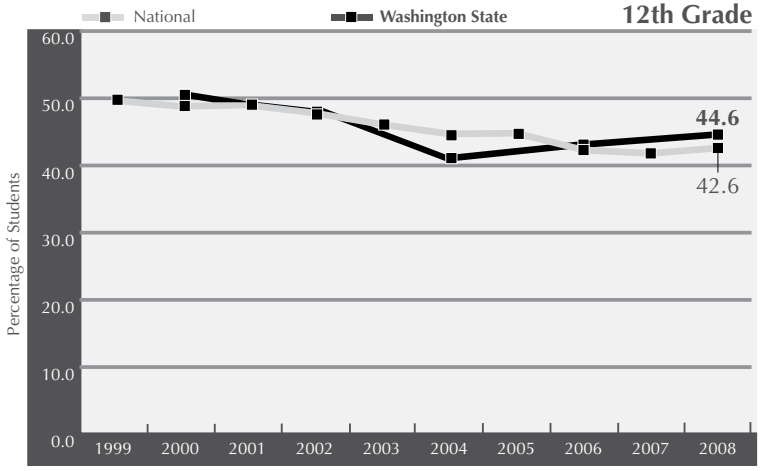
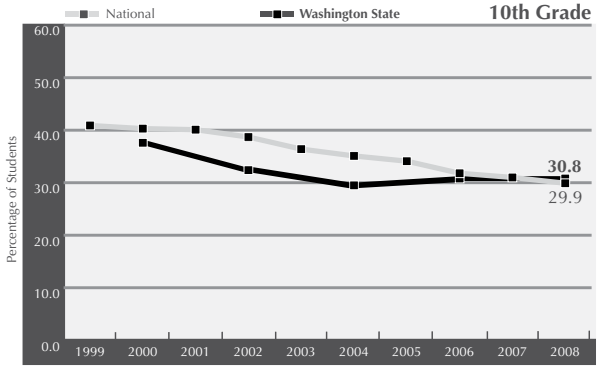
# In 2008, the Percentage of 8th and 12th Grade Students Who Had Tried Marijuana Increased Slightly.*

Besides being associated with a variety of health risks, marijuana use can contribute to risky behaviors and adverse physical and social consequences. The state target is to raise the average age of adolescents' first use of marijuana to 16.

A 2002 national study indicates that 36% of youth ages 14-17 report they can purchase illegal drugs within five blocks of their home.[1] In 2005, Washington State spent more than an estimated $740 million in the public education system, representing 13.1% of all state government spending on elementary and secondary education, to deal with the impacts of youth substance abuse.[2]




Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey*.

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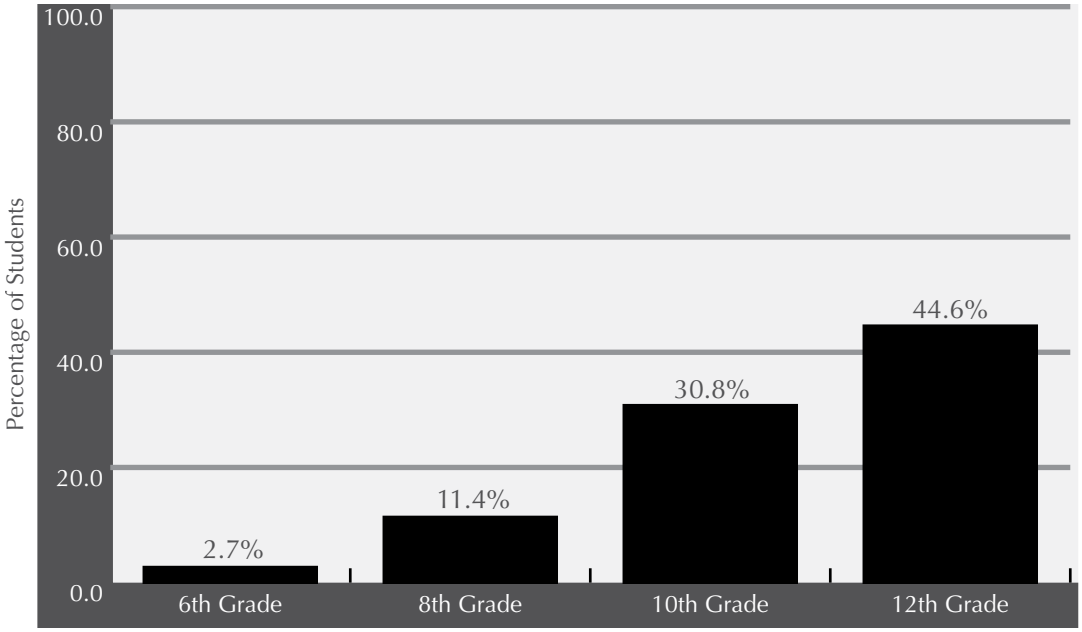
[1] Institute for Adolescent Risk Communication. *Access to Risky Products and Perceptions of Risky Behavior and Popularity*. Philadelphia, PA: University of Pennsylvania, Annenberg Public Policy Center, 2002.
[2] National Center on Addiction and Substance Abuse at Columbia University (CASA). *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*. New York, NY CASA: May 2009.

# By 12th Grade, Over 40% of Washington Students Have Tried Marijuana.




Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008*.

Many Washington students begin use of marijuana while they are in middle school. A study conducted by the National Center on Addiction and Substance Abuse at Columbia University (CASA) found that substance abuse and addiction nationally added $41 billion, or 10%, to the cost of elementary and secondary education in 2001 due to class disruption and violence, special education and tutoring, teacher turnover, children being left behind, student assistance programs, property damage, injury, and counseling.

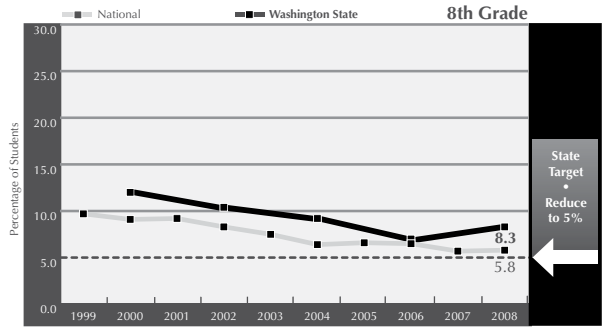
CASA also estimates that 60% of high school students and 30% of middle school students attend schools where illegal drugs are kept, sold, and used. Among 10th graders surveyed, 87% said it was easy to get tobacco, 88% to obtain alcohol, and 78% to get marijuana.[1]

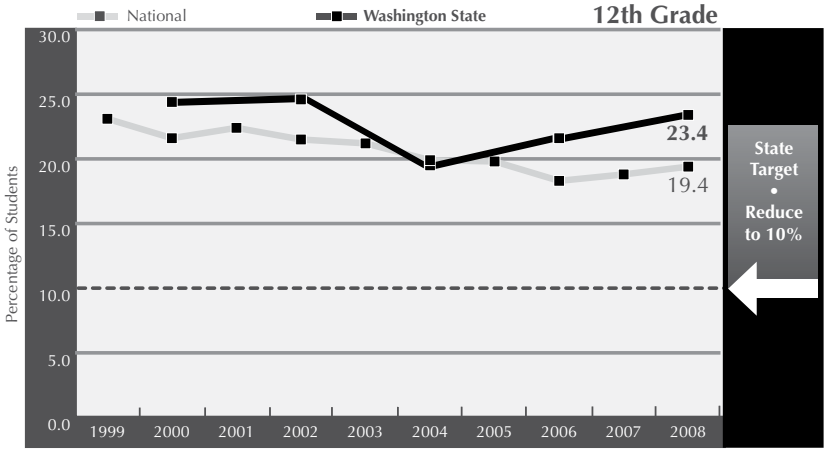


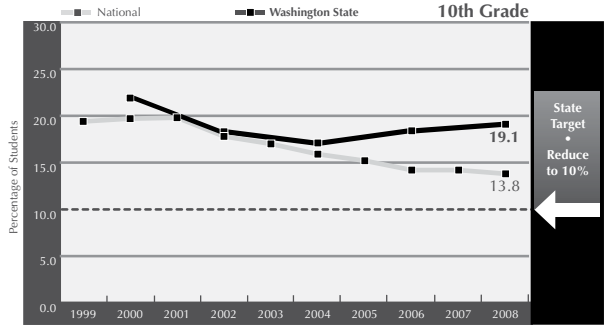
[1] *Malignant Neglect: Substance Abuse and America's Schools*. New York, NY: The National Center on Addiction and Substance Abuse at Columbia University, 2001.

# Marijuana Use in the Past 30 Days Among Washington State Students is Increasing.*

In 2008, marijuana use in the past 30 days among Washington State 8th, 10th, and 12th graders is increased. It remains significantly above the national rate.



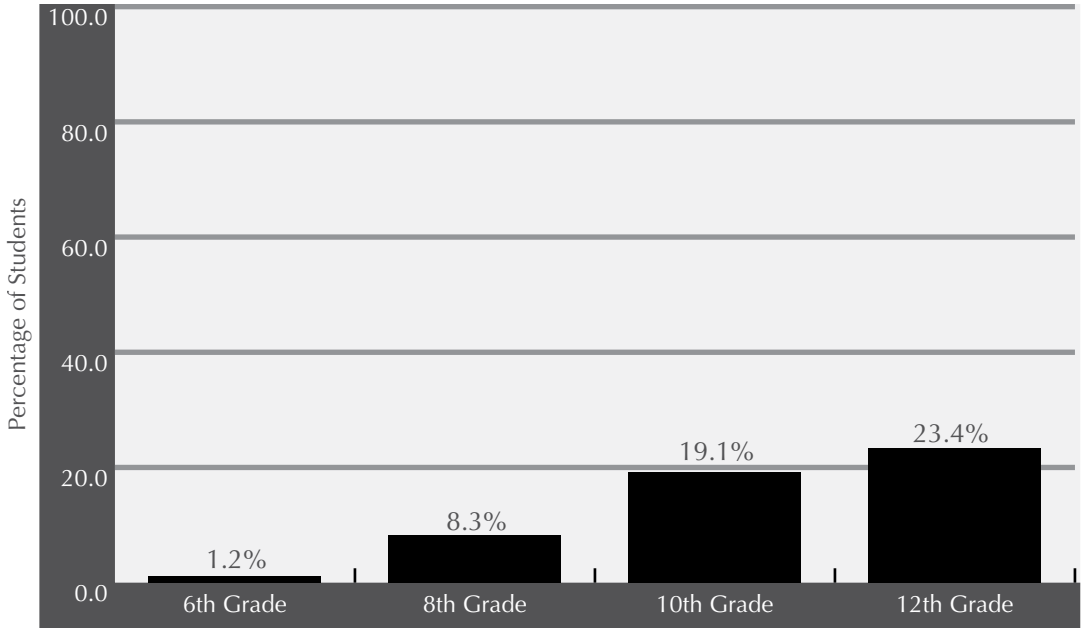




Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey.*

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

# Almost a Quarter of Washington High School Seniors Report Having Used Marijuana in the Past 30 Days.




Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008*.

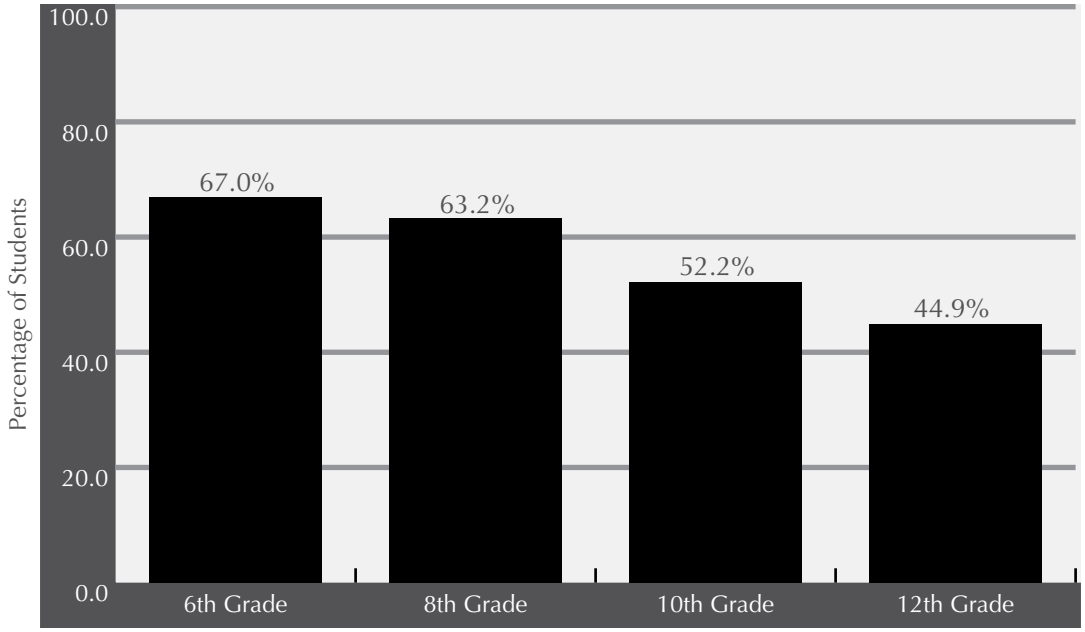
Marijuana use among adolescents follows a predictable pattern, with the highest incidence of use occurring among high school seniors. *Healthy People 2010* recommends a multicomponent approach to youth substance abuse prevention to increase the effectiveness of efforts. Such an approach would include focusing on mobilizing and leveraging resources, raising public awareness, and countering pro-use messages.[1]

A survey conducted by the National Center on Addiction and Substance Abuse at Columbia University found that a plurality of teens (28%) listed alcohol, tobacco, and other drugs as the number one concern facing youth, compared to only 17% of their parents, who thought that social pressures and relationships top the list.[2]



[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-28. Washington, DC: 2000.
[2] National Center on Addiction and Substance Abuse at Columbia University (CASA). *National Survey of American Attitudes on Substance Abuse XIII: Teens and Parents*. New York, NY: CASA, August 2008

# The Percentage of Washington State Students Who Perceive Great Risk from Regular Marijuana Use Declines as They Get Older.

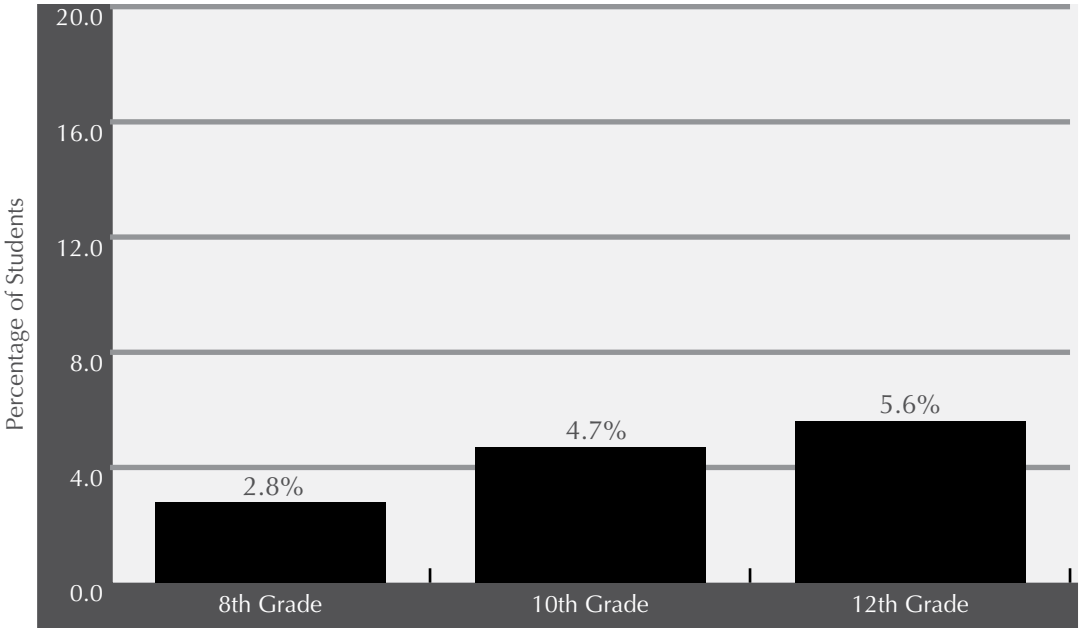



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008*.

The percentage of students in Washington State and nationally, who perceive great risk from regular marijuana use declines as they get older. This is contrary to the way students perceive the risk of regular cigarette use, which increases with age.

NEW/CHANGING TREND

# In 2008, the Percentage of Washington State High School Students Who Reported Having Tried Methamphetamine Declined Significantly.




Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008.*

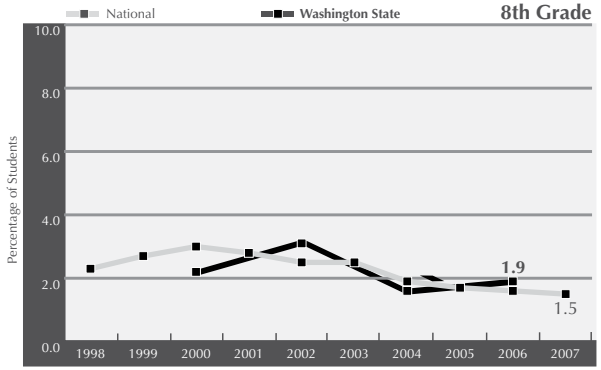
The percentage of Washington State 12th graders who reported they had tried methamphetamine at least once in their lifetime dropped by 21% between 2006 and 2008. Lifetime use by 8th and 10th graders showed similar declines. Treatment admissions for youth where methamphetamine is the primary substance of abuse declined by more than half between SFY 2006 and SFY 2008.[1] The number of reported methamphetamine laboratories and dump sites in Washington State has also dropped more than 90% since its high in 2001.[2]

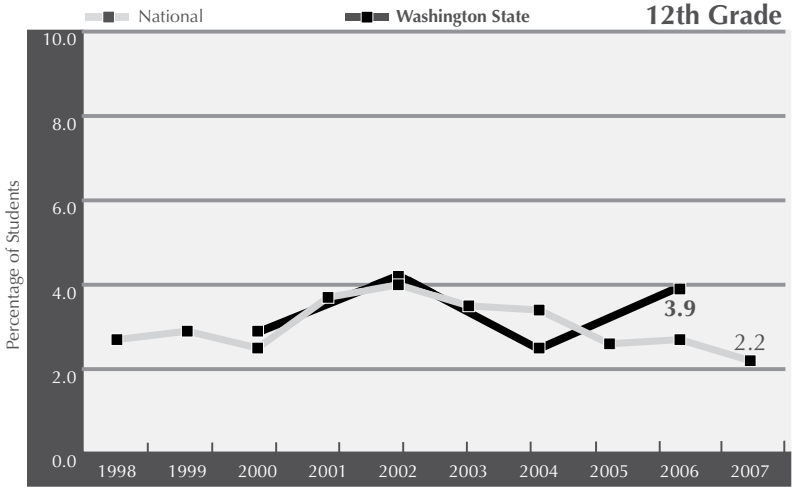


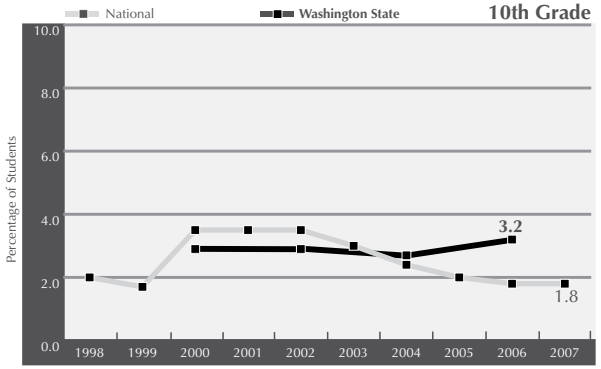
[1] Treatment and Assessment Report General Tool (TARGET). Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.
[2] Washington State Department of Ecology, 2009.

# In 2006, There were Significant Increases in Lifetime Steroid Use Among Washington Students in 8th, 10th, and 12 Grades.*

Behavioral and health problems associated with steroid use include suicides, homicides, liver damage, and heart attacks.[1] Lifetime steroid use among Washington students appears to again be on the rise, and is higher than the national rate.



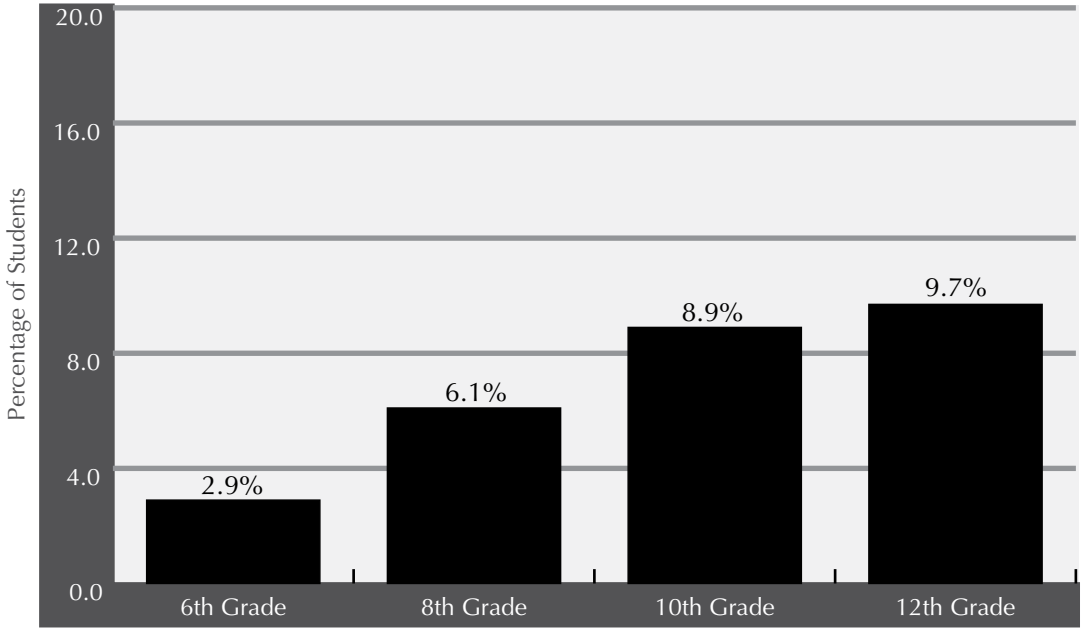

Source: National data from the National Institute on Drug Abuse, *Monitoring the Future*. State data from the Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey*.

* The Washington State Healthy Youth Survey (HYS) is now administered in October. Prior to 2000, it was administered at different and varying times throughout the school year, rendering comparisons with more recent data suspect. The national Monitoring the Future Survey (MTF) is administered in the spring. The result is that Washington State students are younger than those surveyed by MTF, with correspondingly less time in school. Direct comparisons of data points between HYS and MTF thus should not be made, except for the purpose of viewing trends.

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-36. Washington, DC: 2000.

NEW/CHANGING TREND

# In 2008, Reported Lifetime Use of Inhalants Among Washington State 8th, 10th, and 12th Grade Students was Significantly Higher than in 2004.




Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008*.

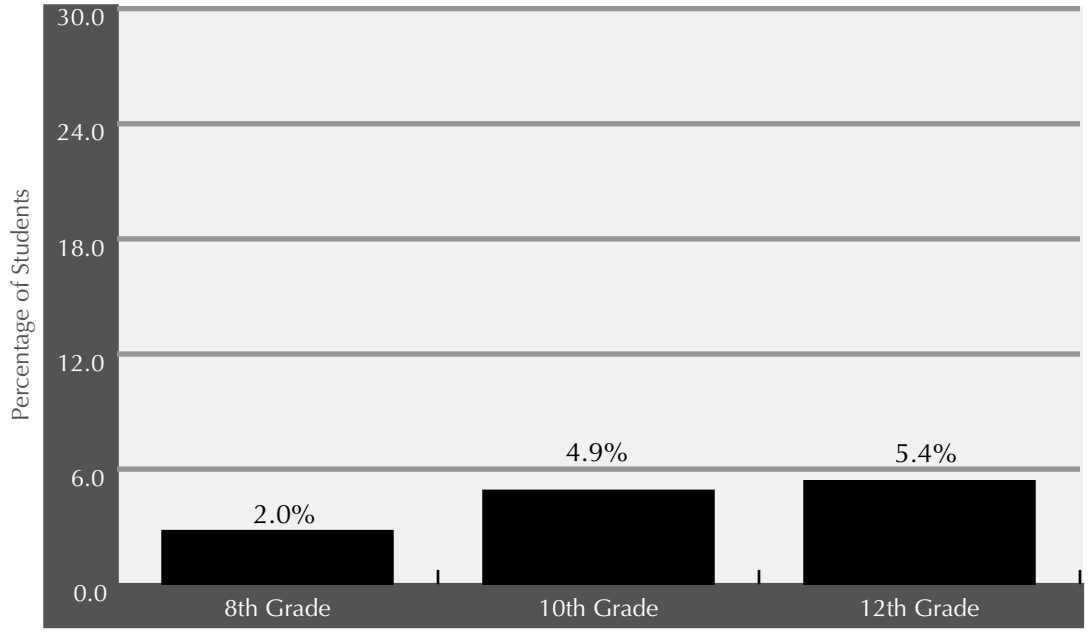
Inhalants are substances whose vapors can be inhaled to produce a mind-altering effect. These include volatile solvents (paint thinners, degreasers, and glue); aerosols (hair sprays and vegetable oil sprays); ether, nitrous oxide, and propane; and nitrites. A single, prolonged session of inhalant use can produce rapid and irregular heart rhythms, heart failure, and death. Chronic exposure can cause widespread and long-lasting damage to the nervous system and other vital organs.[1]

Reported lifetime use of inhalants among Washington State students has increased significantly since 2004. Among 12th graders, it rose from 7.1% to 9.7%, representing a 39% increase; among 10th graders, from 6.6% to 8.9%, representing a 35% increase, and among 8th graders, from 5.3% to 6.1%, representing a 15% increase.



[1] National Institute on Drug Abuse. "Facts About Inhalant Abuse," *NIDA Notes* 15(6), January 2001.

# In 2008, About 5% of Washington State 10th and 12th Graders Reported Using Ritalin Illicitly in the Past 30 Days.



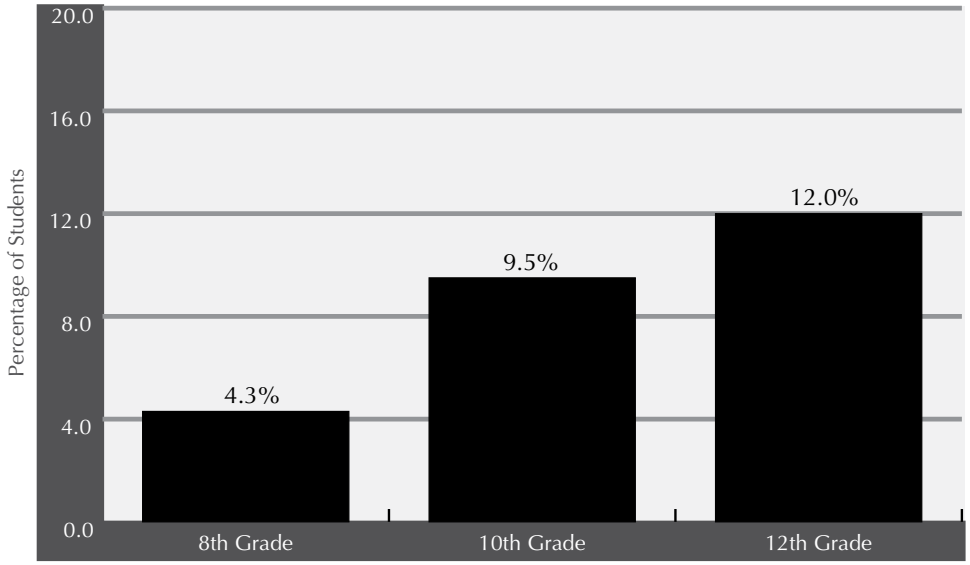

Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, and Family Policy Council, *Healthy Youth Survey - 2006*.

Illicit use of Ritalin by high school students nationwide appears to be on the increase. A recent study found that 10% of youth ages 12-17 had abused Ritalin (and Adderall) at least once. The euphoria produced by excessive, intranasal, or intravenous use of Ritalin is similar to that produced by cocaine and other amphetamines. High doses can lead to delirium, hallucination, and toxic psychosis.[1]

*Healthy Youth Survey* data underestimate the abuse of psycho-stimulants often prescribed to children. Ritalin is only one medication included in this class of drugs, which includes Adderall, Concerta, and other drugs with abuse potential.

[1] The National Center on Addiction and Substance Abuse at Columbia University (CASA). *Under the Counter: The Diversion and Abuse of Controlled Prescription Drugs in the United States*. New York, NY: CASA, July 2005.

# About One in Eight Washington State 12th Graders Used Prescription Pain Relievers to Get High in the Past 30 Days.




Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008.*

In 2008, some 12% of Washington State 12th grades used prescription pain relievers "to get high" in the past 30 days, more than twice the percentage of those who had used methamphetamine even once in their lifetime. Of these, slightly more than half (6.1% of all 12th graders) had used them three or more times, suggesting a risk for addiction or other serious consequences.

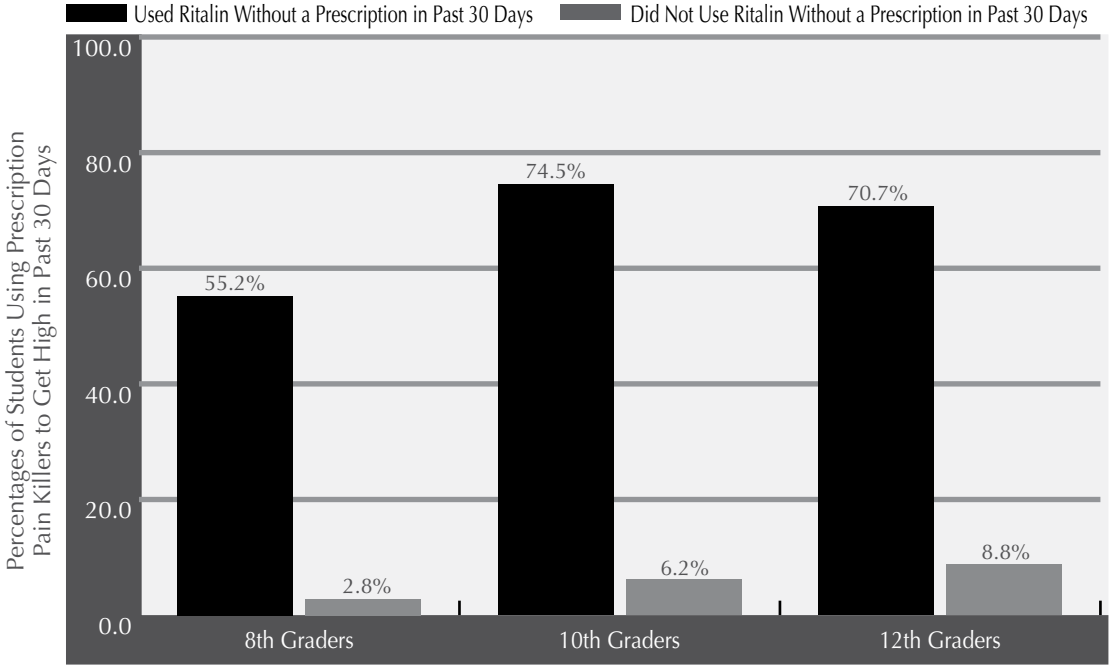
Maintaining a balance between providing adequate pain management and preventing misuse of prescription-opiates* presents a challenge for policymakers. Approximately 19% of U.S. adults received a prescription for opiates in 2005. Sales of prescription opiates - especially oxycodone, hydrocodone, and methadone - have grown rapidly in the past decade, as have related emergency department visits, and drug-caused deaths in which prescription-type opiates are present.[1] It is thought that the general household availability of prescription-type opiates is a factor in abuse of these drugs by youth. Among those 10th graders who used prescription pain relievers to get high in the past 30 days, 36% most commonly got them from a friend or acquaintance, 21% got them from their own prescriptions from a doctor or dentist, 15% took them from their own or someone else's home without permission, and 11% got them from a family member.[2]

**Prescription-type opiates include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oyxcodone, and propoxyphene.*



[1] Banta-Green, C., et al. *The Use & Abuse of Prescription-Type Opiates in Washington State (ADAI Research Brief).* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, March 30, 2007.
[2] Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board. *Healthy Youth Survey – 2008.* Olympia, WA: 2009.

# Among Washington State Students, There is a Strong Association Between Use of Ritalin Without a Prescription and Use of Prescription Pain Killers to Get High.



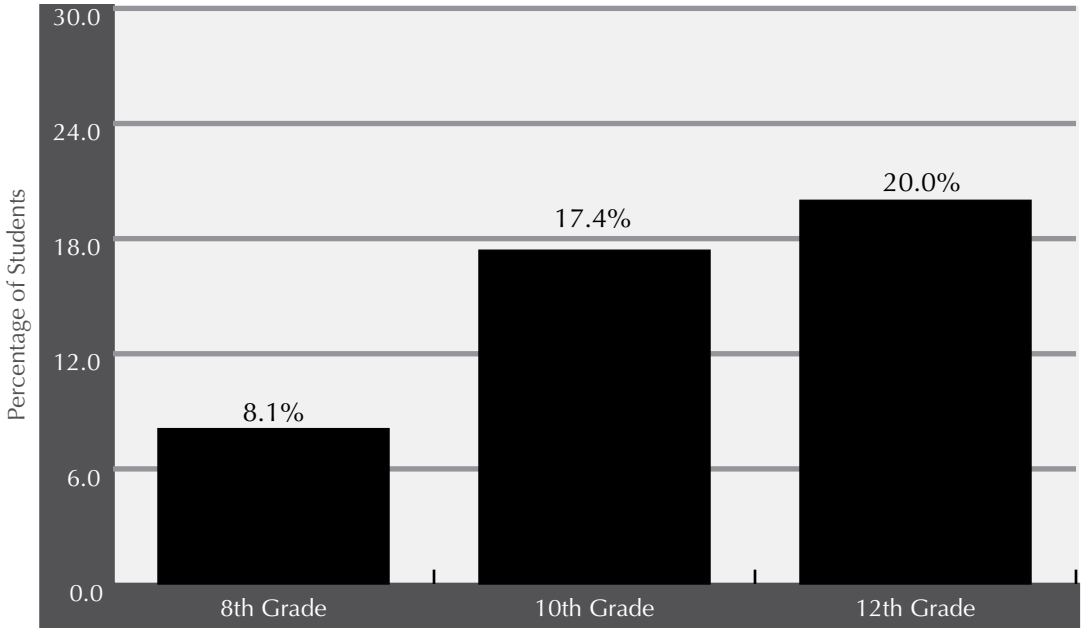

Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey – 2008.*

The psychopharmacological effects of psychostimulants such as Ritalin and prescription pain killers (usually prescription-type opiates* are different, with the first class of drugs being stimulants and the second being system depressants. What they have in common is that they are both diverted from their prescriptive use by youths for illicit purposes. More research is needed on effective ways to prevent youth from misusing all prescription drugs.

**Prescription-type opiates include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oyxcodone, and propoxyphene.*

NEW/CHANGING TREND

# One-Fifth of Washington State 12th Graders Reported Being Drunk or High at School in the Past Year.




Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2008.*

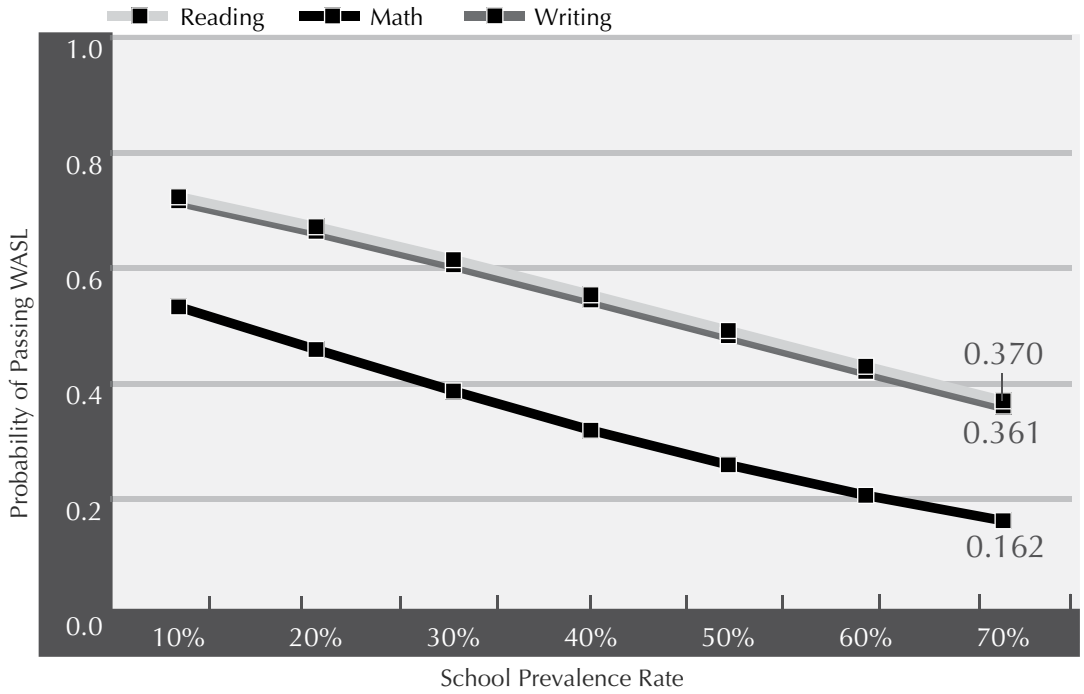
A substantial proportion of Washington State middle and high school students have attended school either drunk or high. Peer substance abuse has been shown to have highly negative effects upon school performance.[1]



[1] Arthur, M., and Brown, E. "Levels of Risk, Protection and Drug Use Predict Students' WASL Scores." Seattle, WA: University of Washington, Social Development Research Group, May 2006.

# Peer Substance Abuse Has Significant Negative Impacts on School Performance.

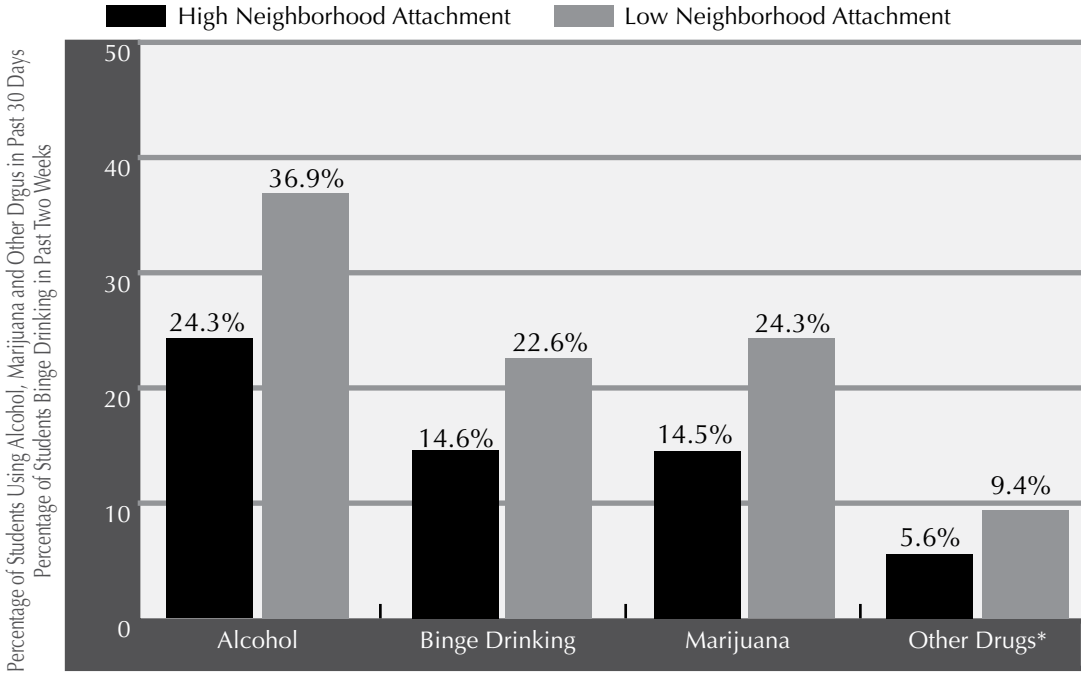
***Relationship Between Past 30-Day Alcohol Use and Probability of Passing WASL (10th Graders)***




Source: Arthur, M., and Brown, E., "Levels of Risk, Protection and Drug Use Predict Students' WASL Scores." Seattle, WA: Social Development Research Group, University of Washington, May 2006.

A 2006 analysis of data from the *Washington State Healthy Youth Survey* indicates a strong relationship between peer substance abuse and school performance. As the prevalence of past-30 day alcohol use within a school population rises, the percentage of those who pass the tenth-grade Washington Assessment of Student Learning (WASL) in math, reading, and writing declines. Therefore, it is likely that successful efforts to curb underage drinking will have significant impacts on student performance.

# Low Neighborhood Attachment is Associated with Higher Past 30-Day Alcohol, Marijuana, and Other Drug Use and Binge Drinking Among Washington State 10th Graders.

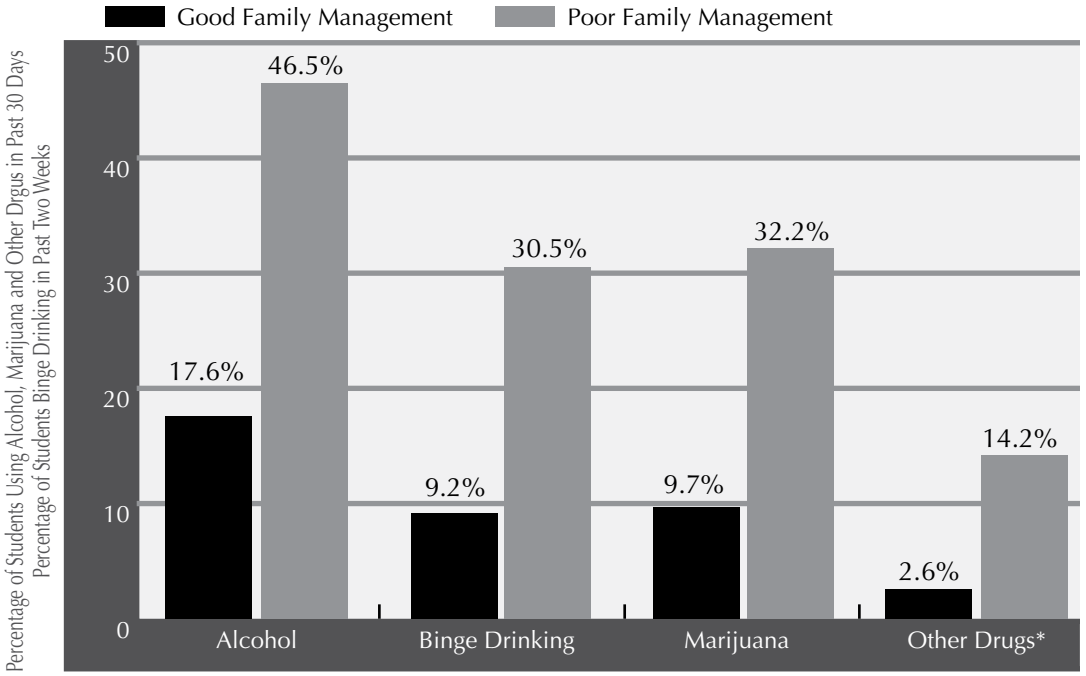



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey – 2008.*

Data gathered from the *Healthy Youth Survey – 2008* indicate a robust association between low neighborhood attachment and the use of alcohol and other drugs. Feeling attached to one community and having opportunities for pro-social involvement in the community have significant protective effects.

**Drugs other than alcohol, tobacco, or marijuana.*

# Poor Family Management is Associated with Higher Past 30-Day Alcohol, Marijuana, and Other Drug Use and Binge Drinking Among Washington State 10th Graders.

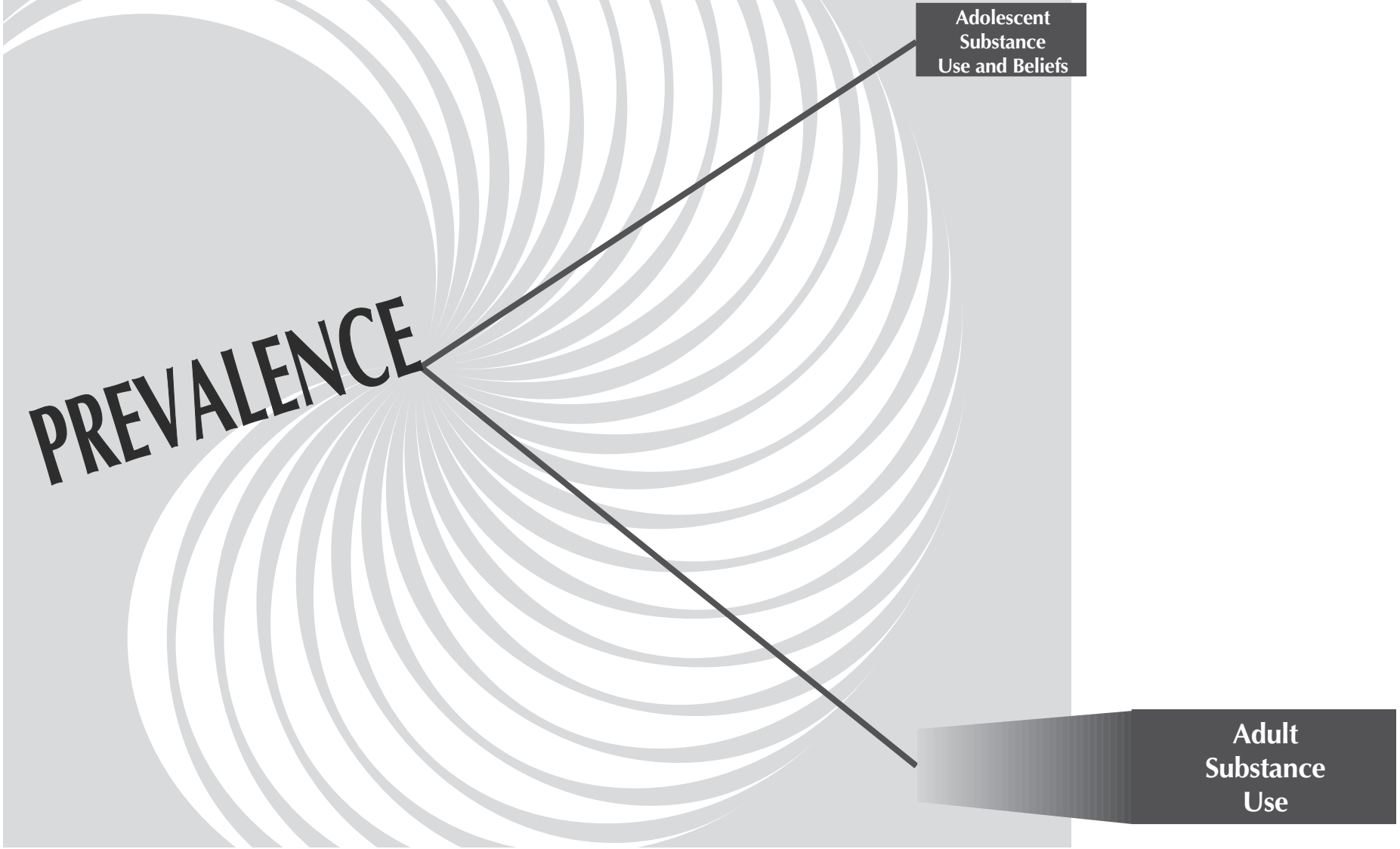



Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey – 2008*.

Data gathered from the *Healthy Youth Survey – 2008* indicates a strong association between poor family management and the use of alcohol and other drugs. Being part of a family in which there are rewards for prosocial involvement has significant protective effects.

**Drugs other than alcohol, tobacco, or marijuana.*

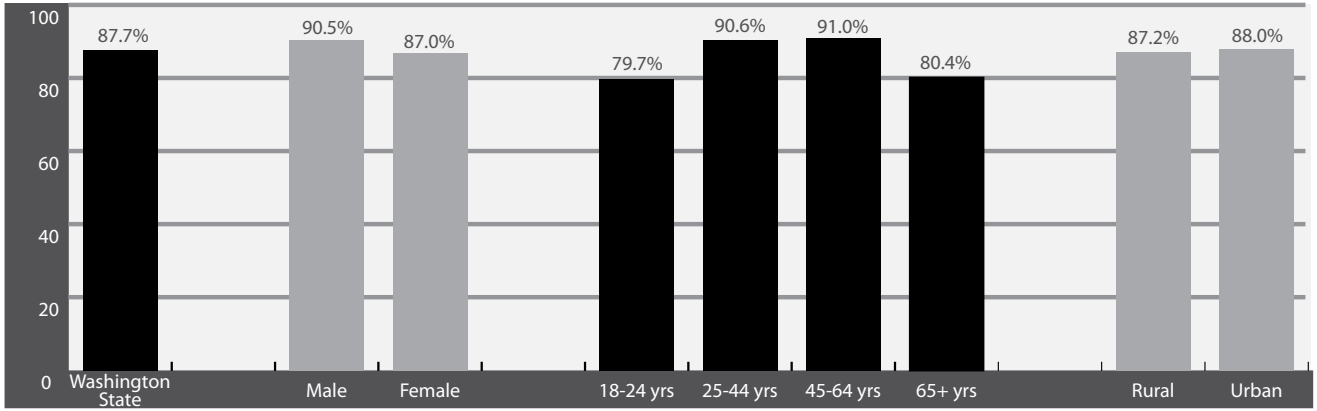
# The Problem: Substance Abuse Prevalence & Trends



# Males and Those Ages 25-44 Have Higher Rates of Alcohol Use.

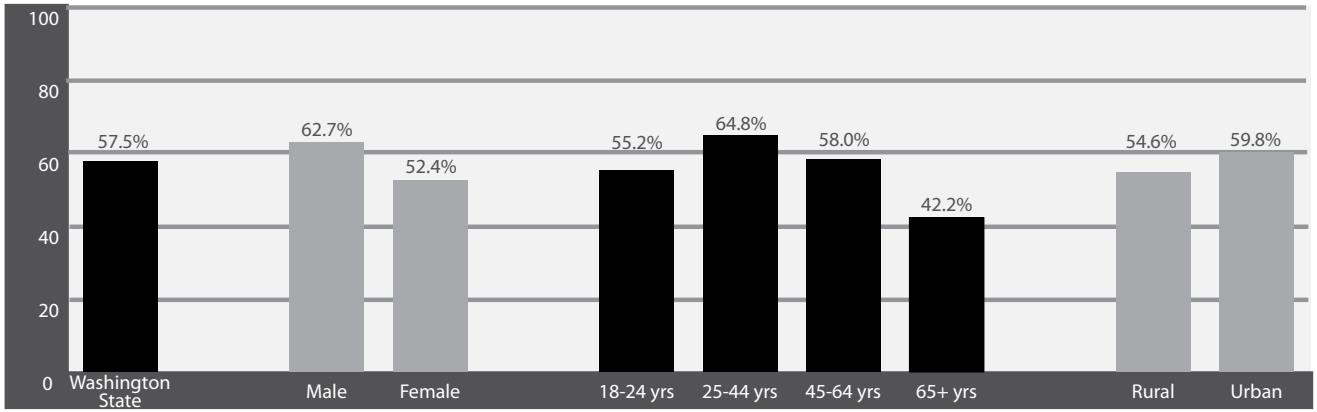
## Lifetime Use of Alcohol

Percent of Adults in Households




## Past 30-Day Use of Alcohol

Percent of Adults in Households



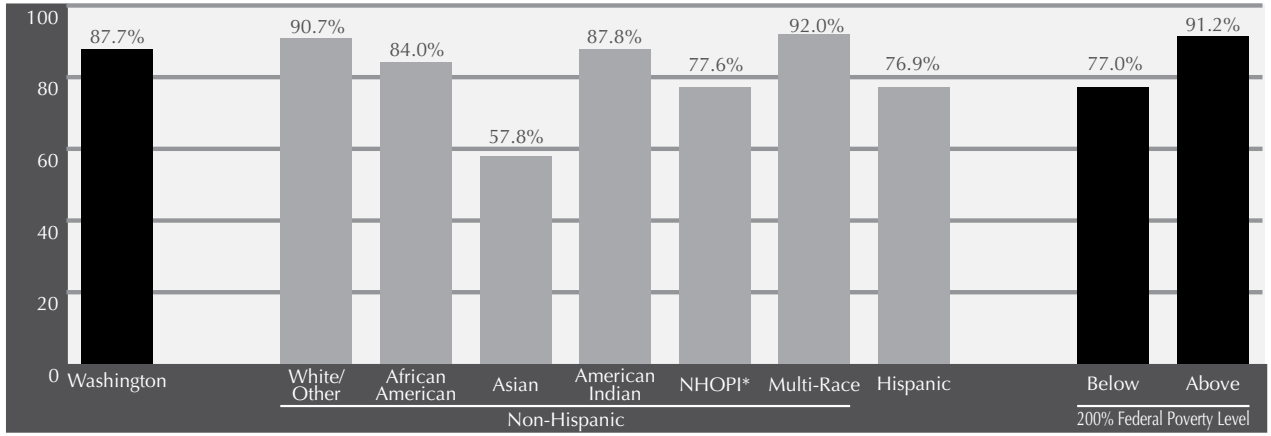

Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2008 Adult Household Residents.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

# Asian-Americans, Hispanics, and Lower-Income Individuals Have Lower Rates of Alcohol Use.

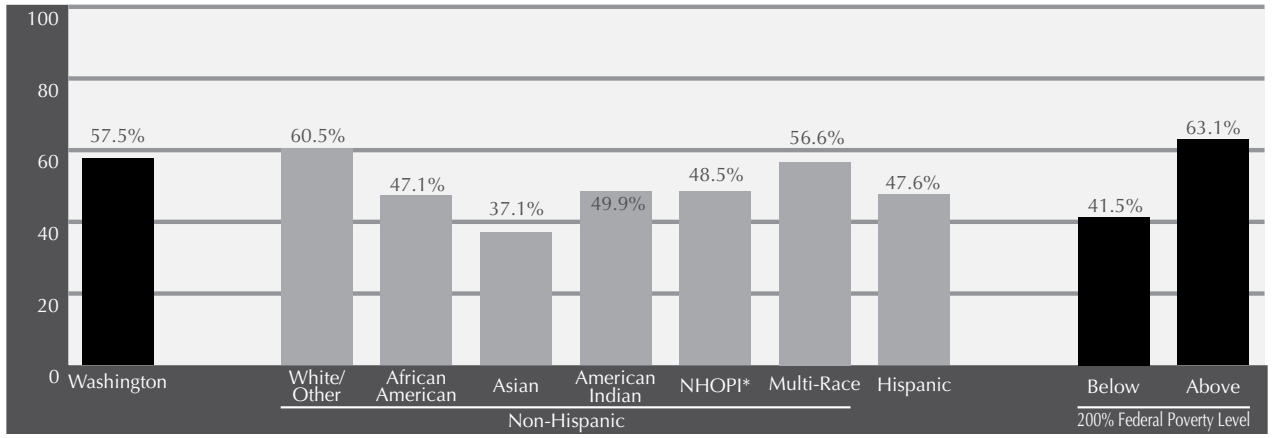
## Lifetime Use of Alcohol

Percent of Adults in Households




## Past 30-Day Use of Alcohol

Percent of Adults in Households




*Native Hawaiian or Pacific Islander

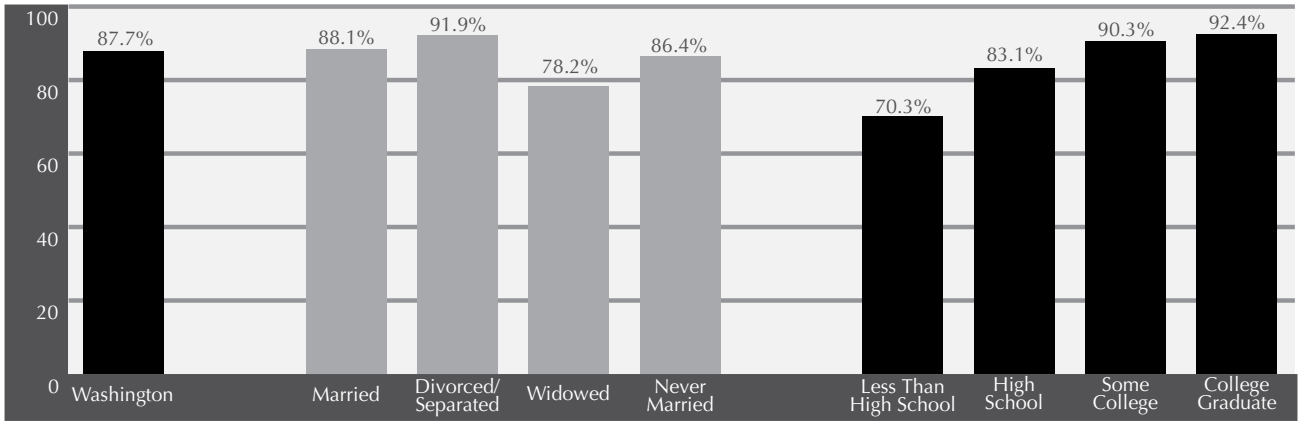
Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2008 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

# Widowed Individuals and Those Who Never Completed High School Have Lower Rates of Alcohol Use.

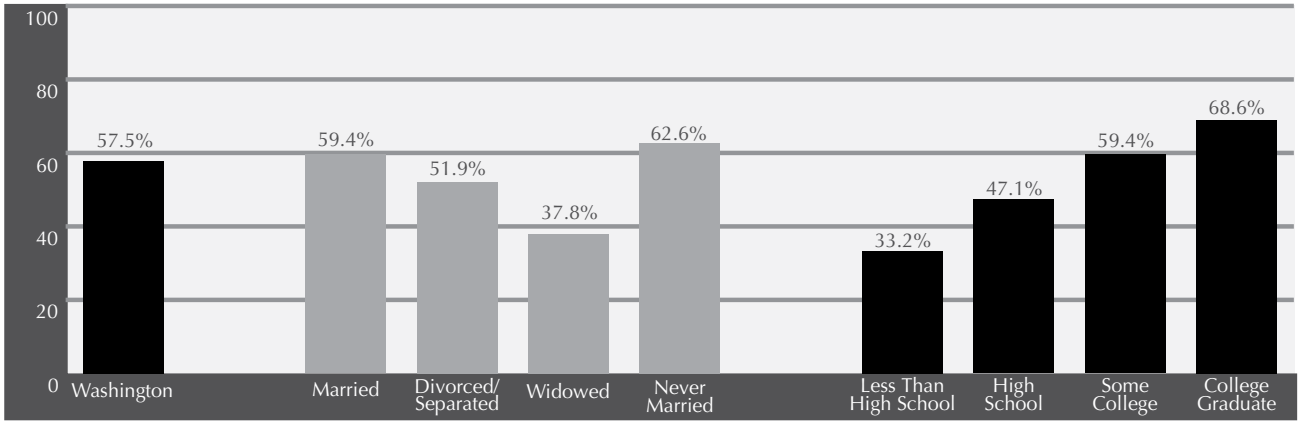
## Lifetime Use of Alcohol

Percent of Adults in Households




## Past 30-Day Use of Alcohol

Percent of Adults in Households

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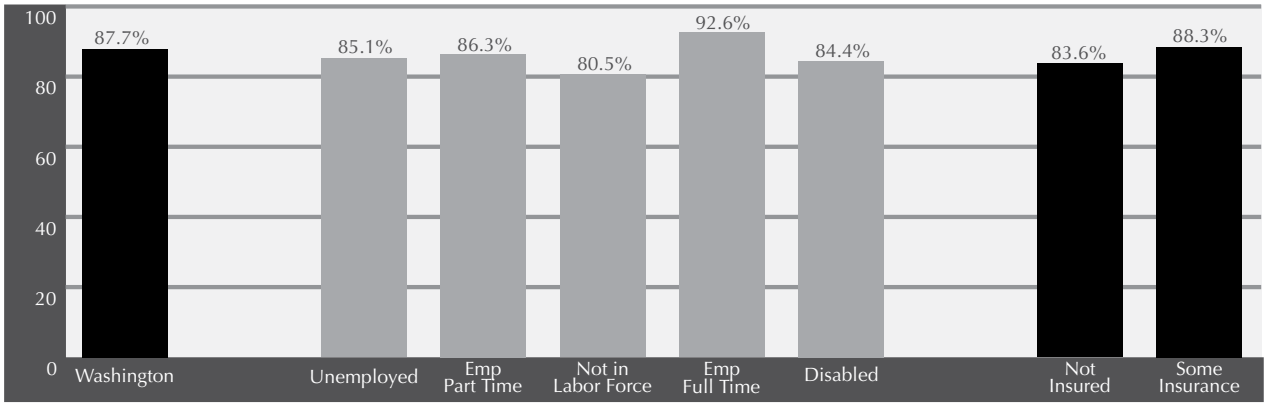
Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

# Individuals Not in the Labor Force and Disabled, or Who are Without Health Insurance are Less Likely to Have Used Alcohol in the Past 30 Days.

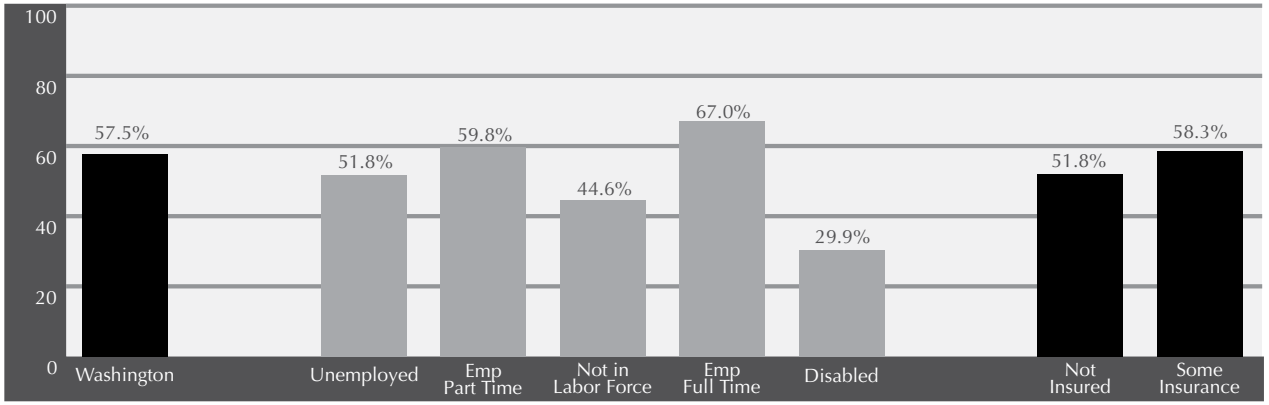
## Lifetime Use of Alcohol

Percent of Adults in Households




## Past 30-Day Use of Alcohol

Percent of Adults in Households

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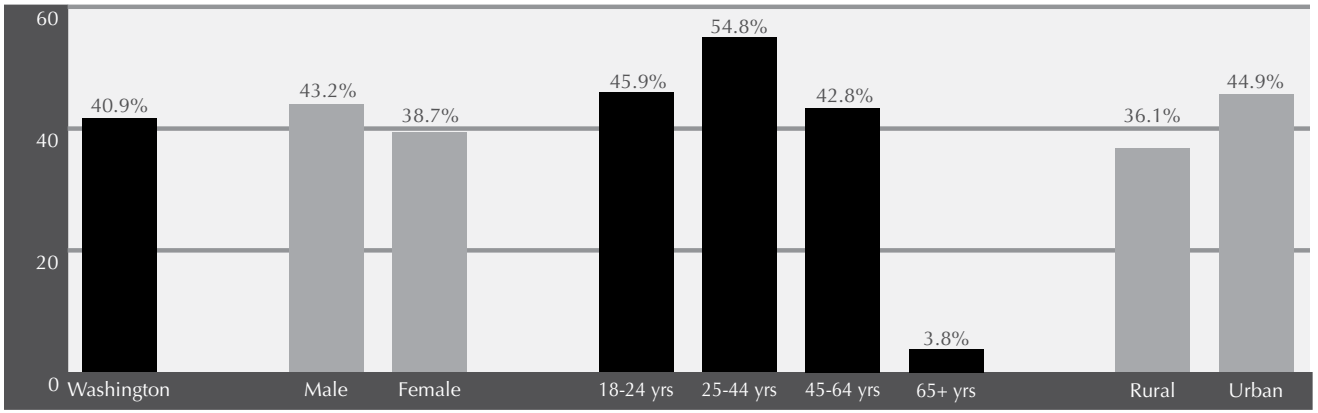
Note: Lifetime Use of Alcohol means having had at least one drink of alcohol at least once in their life.
Note: Past 30-Day Use of Alcohol means having had at least one drink of alcohol during the past 30 days.

# Individuals Over Age 65 and Rural Residents Have Lower Rates of Marijuana Use.

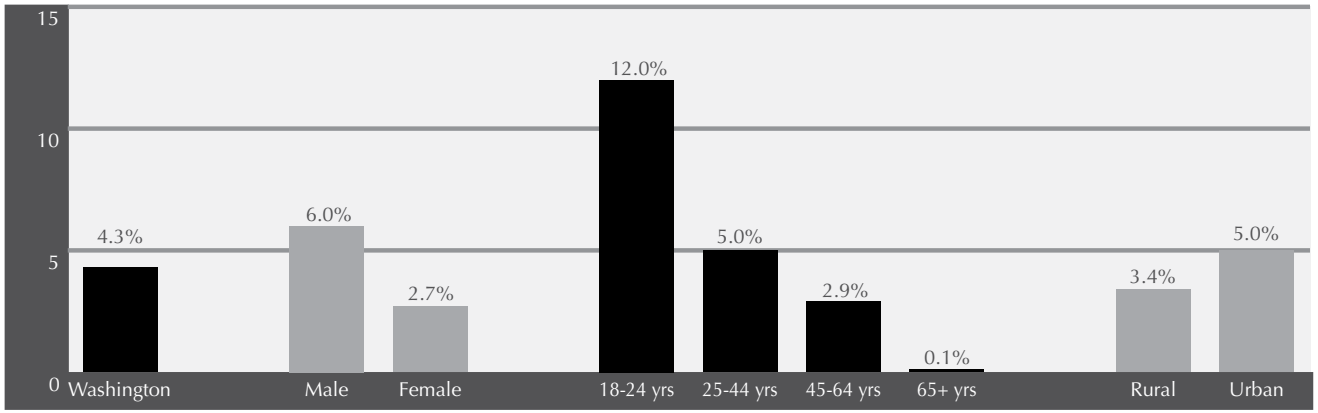
## Lifetime Use of Marijuana

Percent of Adults in Households




## Past 30-Day Use of Marijuana

Percent of Adults in Households



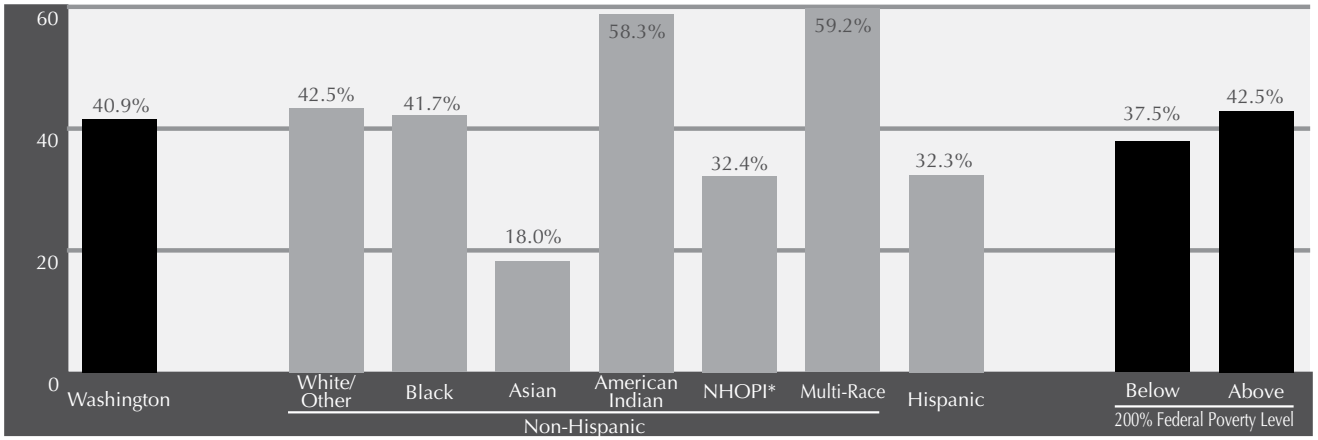

Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2008 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

Note: Lifetime Use of Marijuana means having had at least one usage of marijuana at least once in their life.
Note: Past 30-Day Use of Marijuana means having had at least one usage of marijuana during the past 30 days.

# Asian-Americans and Native Hawaiians/ Pacific Islanders Have Lower Rates of Marijuana Use.

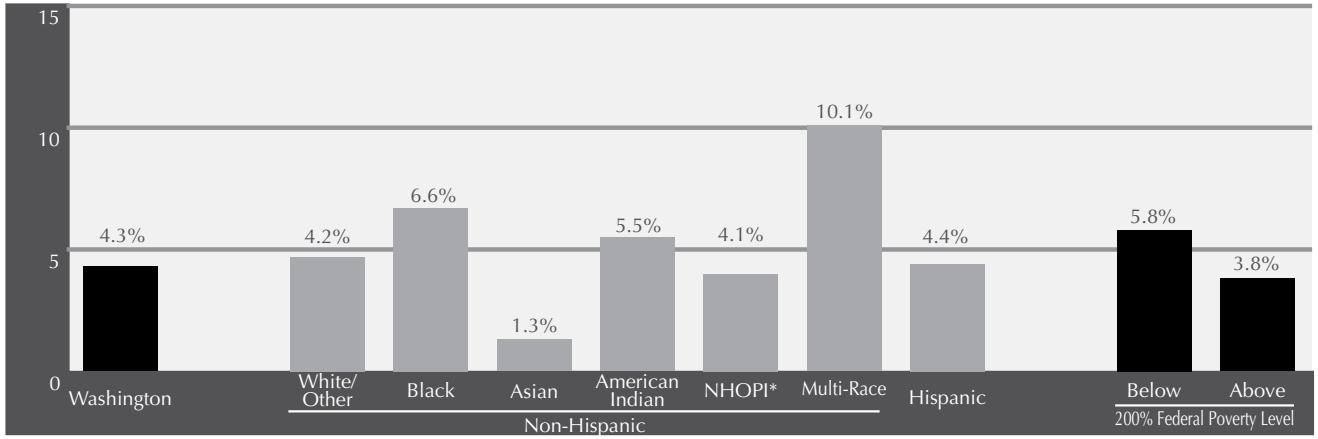
## Lifetime Use of Marijuana

Percent of Adults in Households




## Past 30-Day Use of Marijuana

Percent of Adults in Households




*Native Hawaiian or Pacific Islander

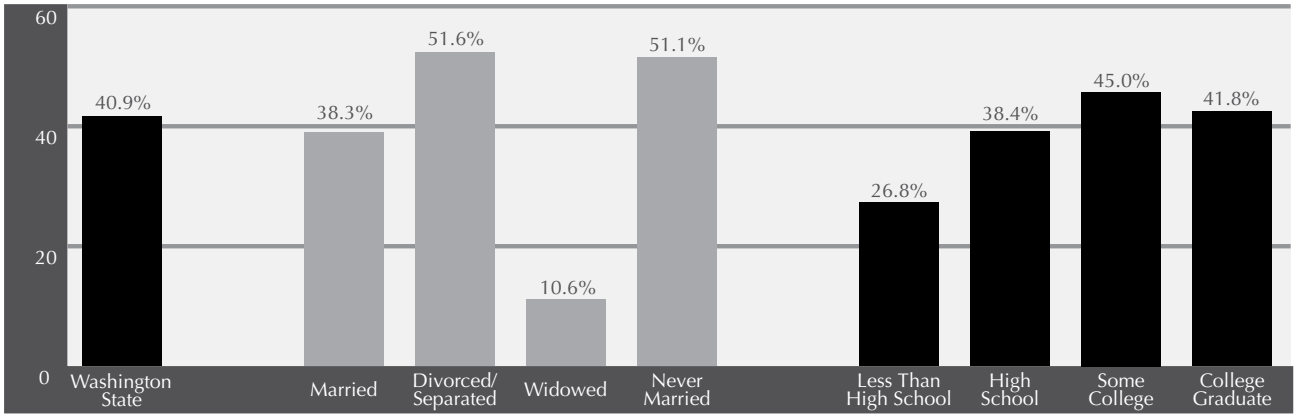
Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2008 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

Note: Lifetime Use of Marijuana means having had at least one usage of marijuana at least once in their life.
Note: Past 30-Day Use of Marijuana means having had at least one usage of marijuana during the past 30 days.

# Widowed Individuals and Those Who Never Completed High School Have Lower Rates of Marijuana Use.

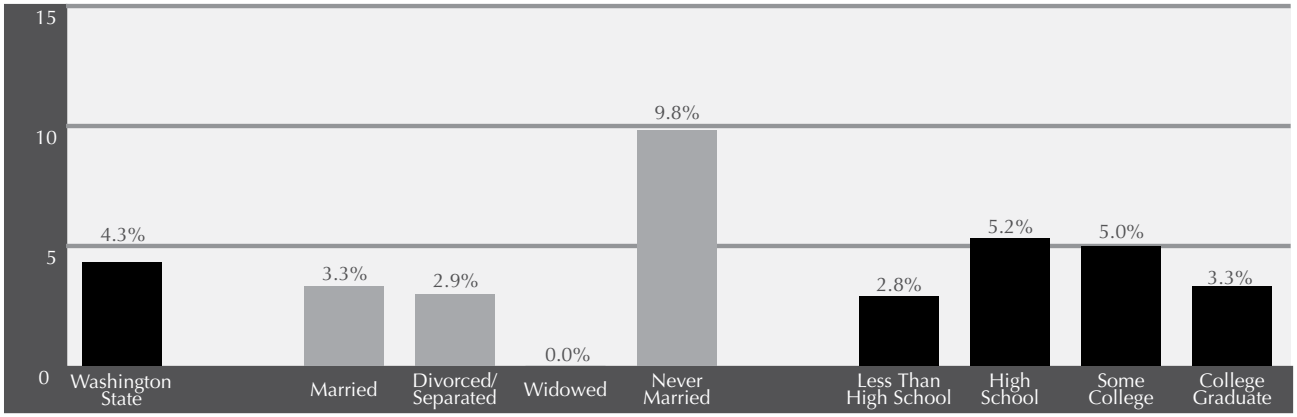
## Lifetime Use of Marijuana

Percent of Adults in Households




## Past 30-Day Use of Marijuana

Percent of Adults in Households



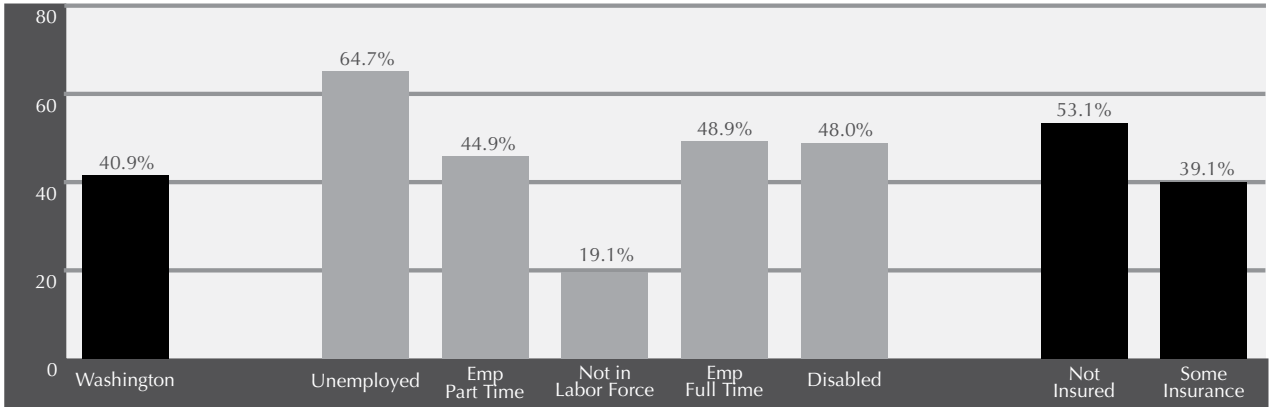

Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2008 Adult Household Residents.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

Note: Lifetime Use of Marijuana means having had at least one usage of marijuana at least once in their life.
Note: Past 30-Day Use of Marijuana means having had at least one usage of marijuana during the past 30 days.

# Individuals Not in the Labor Force, and Those With Health Insurance are Less Likely to Have Used Marijuana in the Past 30 Days.

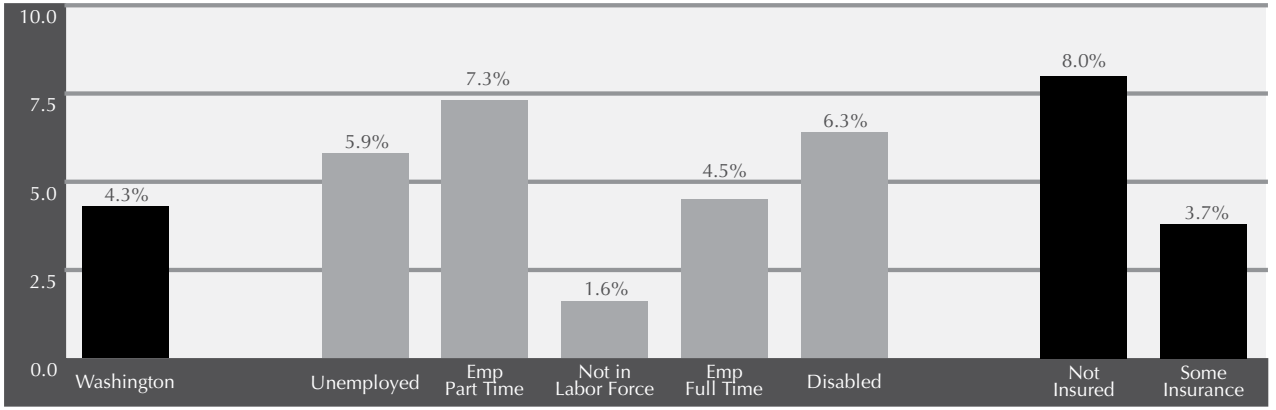
## Lifetime Marijuana Use

Percent of Adults in Households




## Past 30-Day Use of Marijuana

Percent of Adults in Households



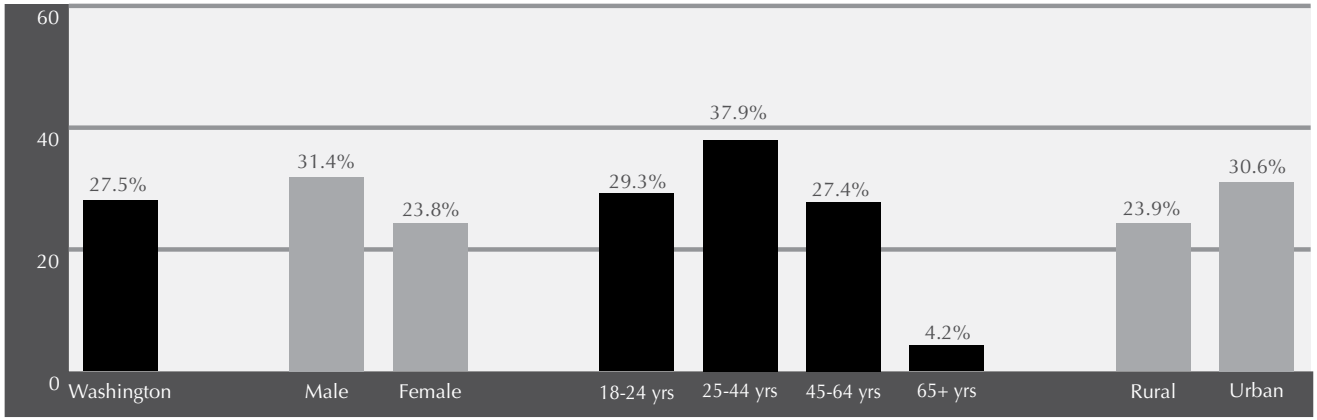

Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2008 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

Note: Lifetime Use of Marijuana means having had at least one usage of marijuana at least once in their life.
Note: Past 30-Day Use of Marijuana means having had at least one usage of marijuana during the past 30 days.

# Individuals Over Age 65 and Rural Residents Have Lower Rates of Use of Illicit Drugs Other than Marijuana.*

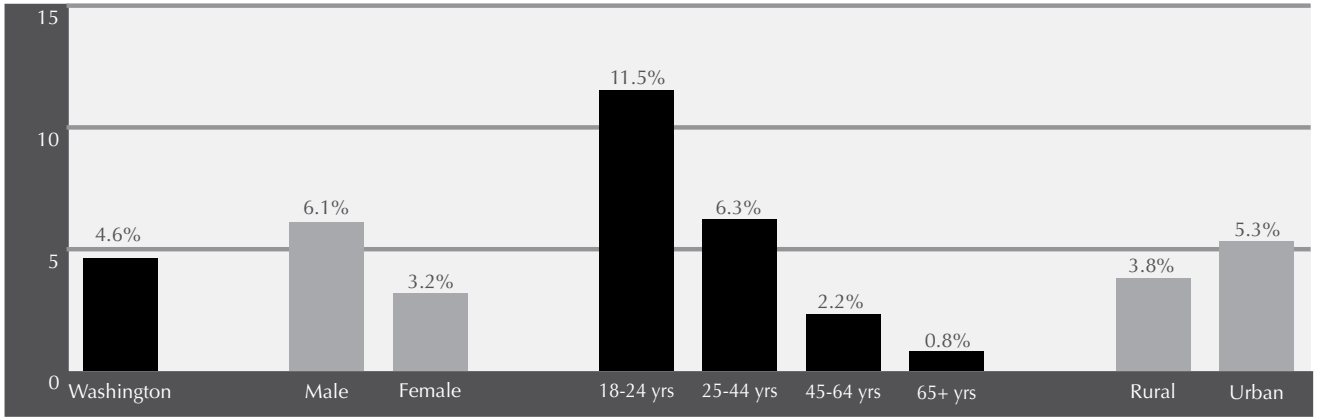
## Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households




## Past 12-Month Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households




Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2008 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

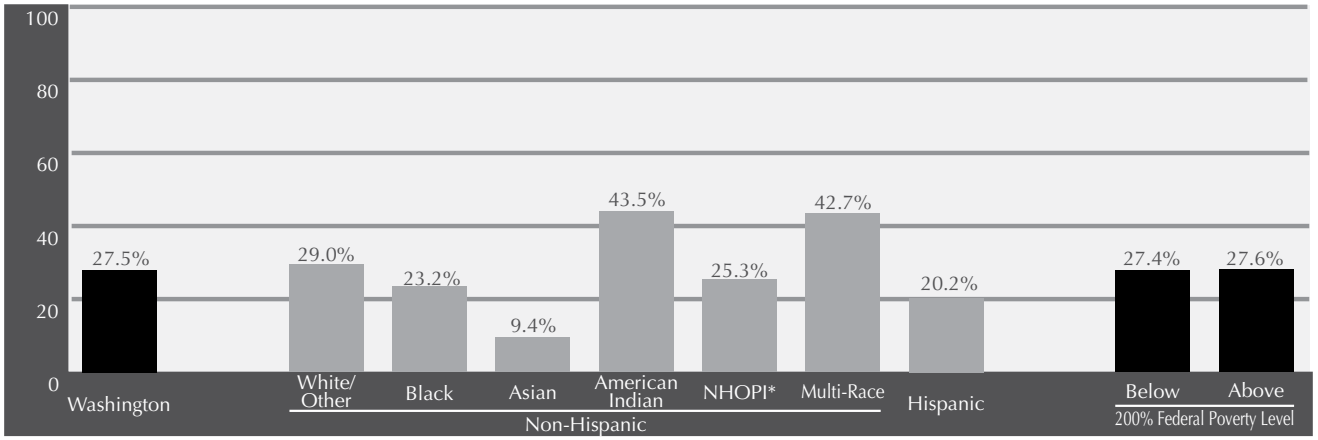
** Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.*

Note: Lifetime Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana at least once in their life.
Note: Past 30-Day Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana during the past 30 days.

# American Indians and Multi-Race Individuals Have Higher Rates of Use of Illicit Drugs Other than Marijuana.*

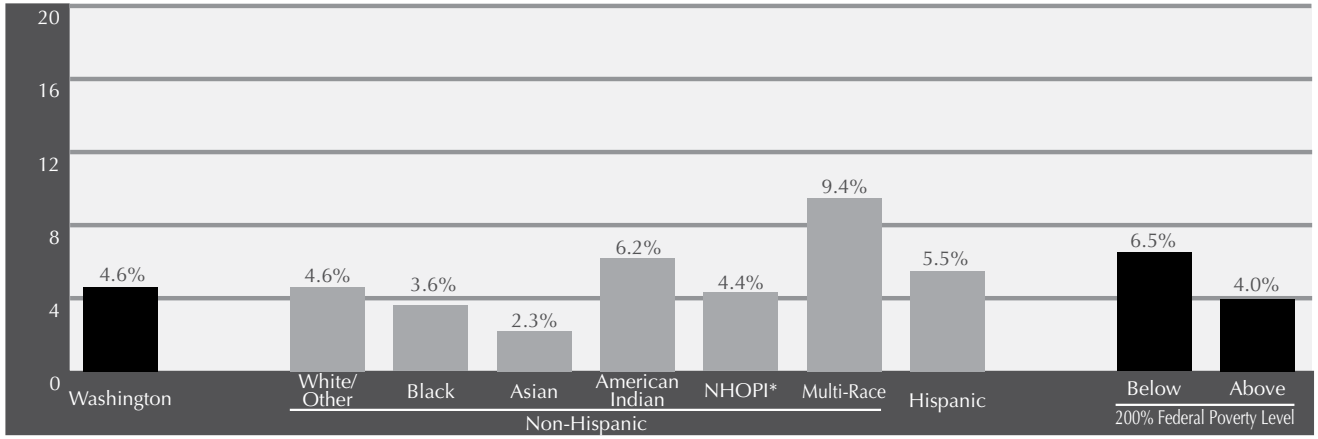
## Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households




## Past 12-Month Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households




**Native Hawaiian or Pacific Islander

Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2008 Adult Household Residents.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

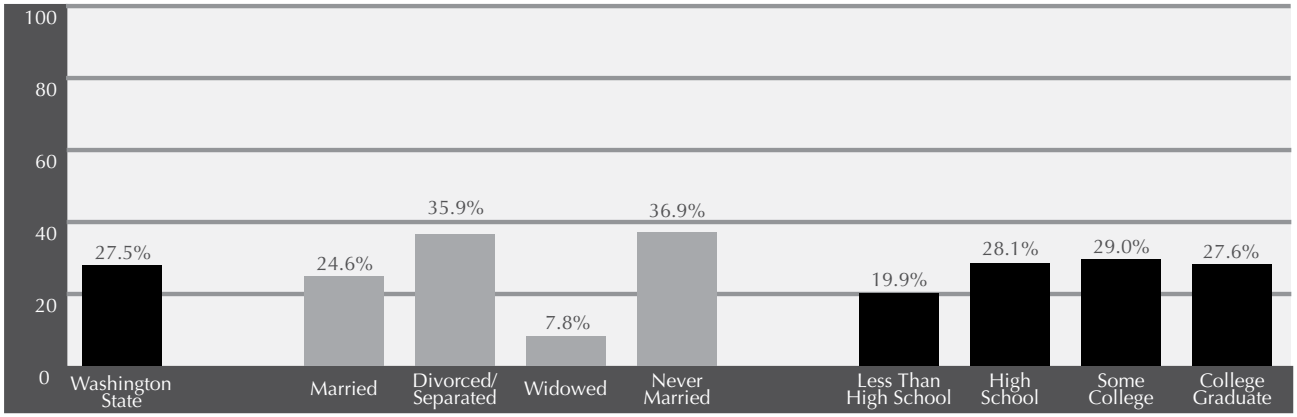
** Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.*

Note: Lifetime Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana at least once in their life.
Note: Past 30-Day Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana during the past 30 days.

# Widowed Individuals and Those Who Never Graduated from High School Have Lower Rates of Use of Illicit Drugs Other than Marijuana.*

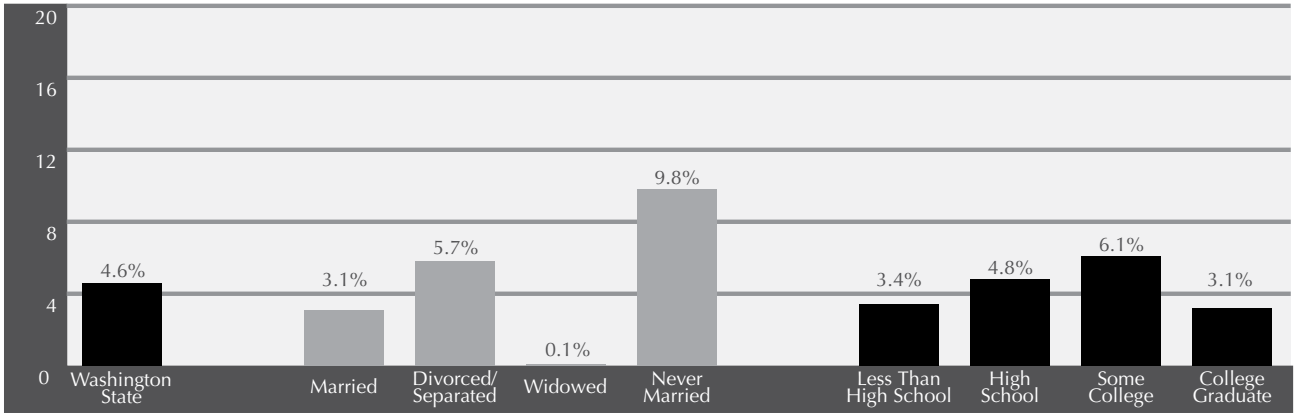
## Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households




## Past 12-Month Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households




Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2008 Adult Household Residents.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

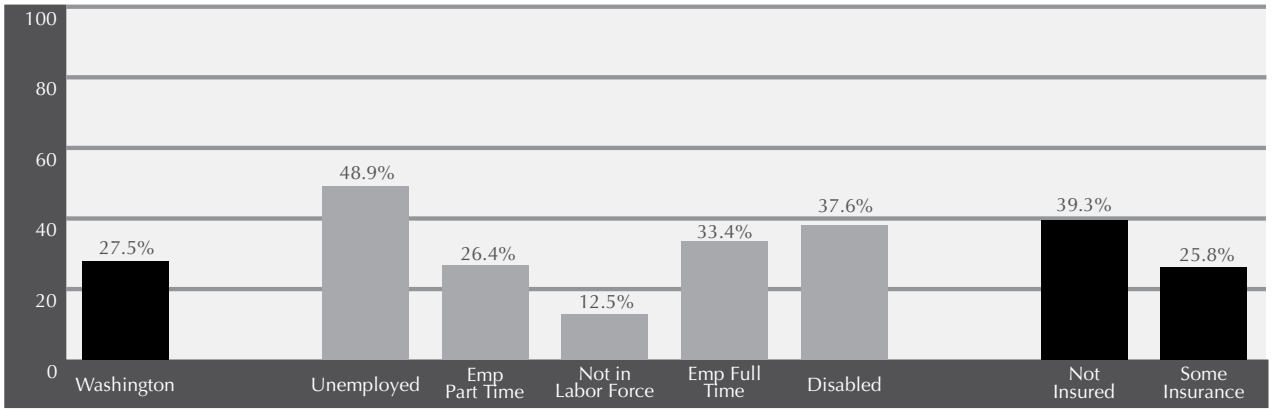
** Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.*

Note: Lifetime Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana at least once in their life.
Note: Past 30-Day Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana during the past 30 days.

# Individuals Who are Unemployed, Disabled, and Lack Health Insurance Have Higher Rates of Use of Illicit Drugs Other than Marijuana.*

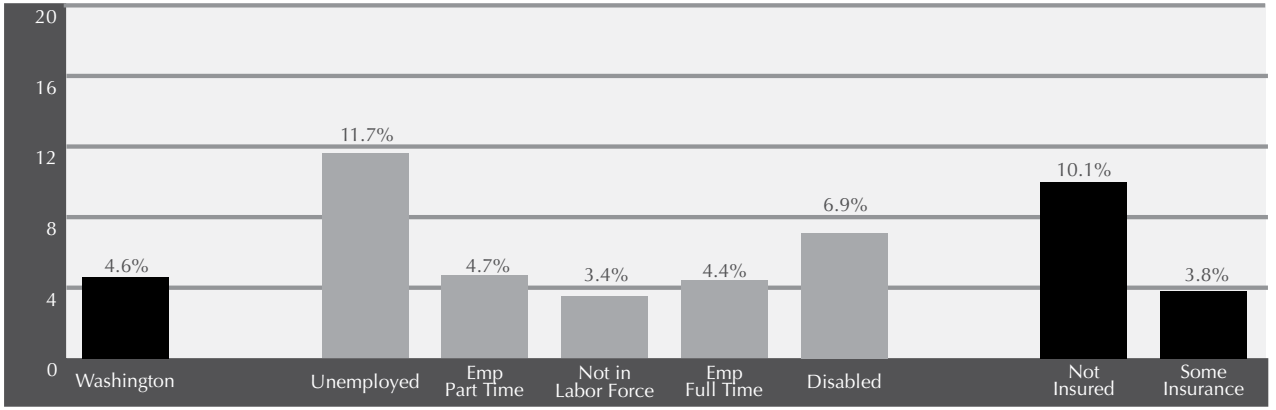
## Lifetime Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households




## Past 12-Months Use of Illicit Drugs Other than Marijuana

Percent of Adults in Households

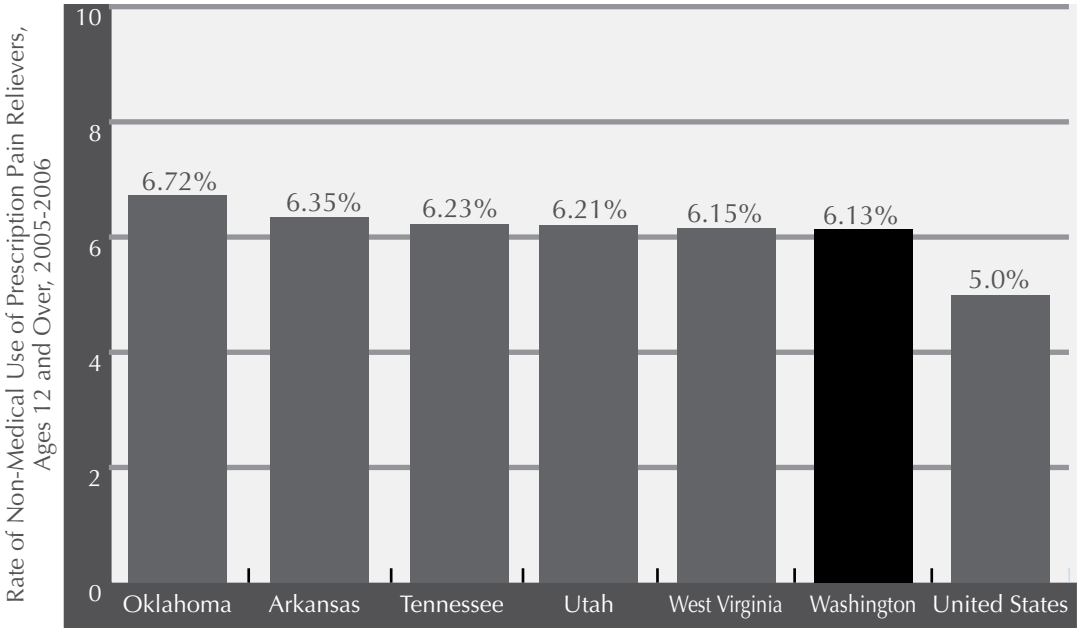



Source: *Estimates of Alcohol, Marijuana, and Illicit Drugs Other Than Marijuana Use in Washington State, 2008 Adult Household Residents*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

** Illicit drugs other than marijuana include cocaine, stimulants, hallucinogens, heroin, opiates, tranquilizers, sedatives, and inhalants.*

Note: Lifetime Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana at least once in their life.
Note: Past 30-Day Use of Illicit Drugs Other than Marijuana means having had at least one usage of illicit drugs other than marijuana during the past 30 days.

# Washington State Has Among the Highest Rates of Non-Medical Use of Prescription Pain Relievers in the Nation.




Source: Office of Applied Studies, *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, 2008.

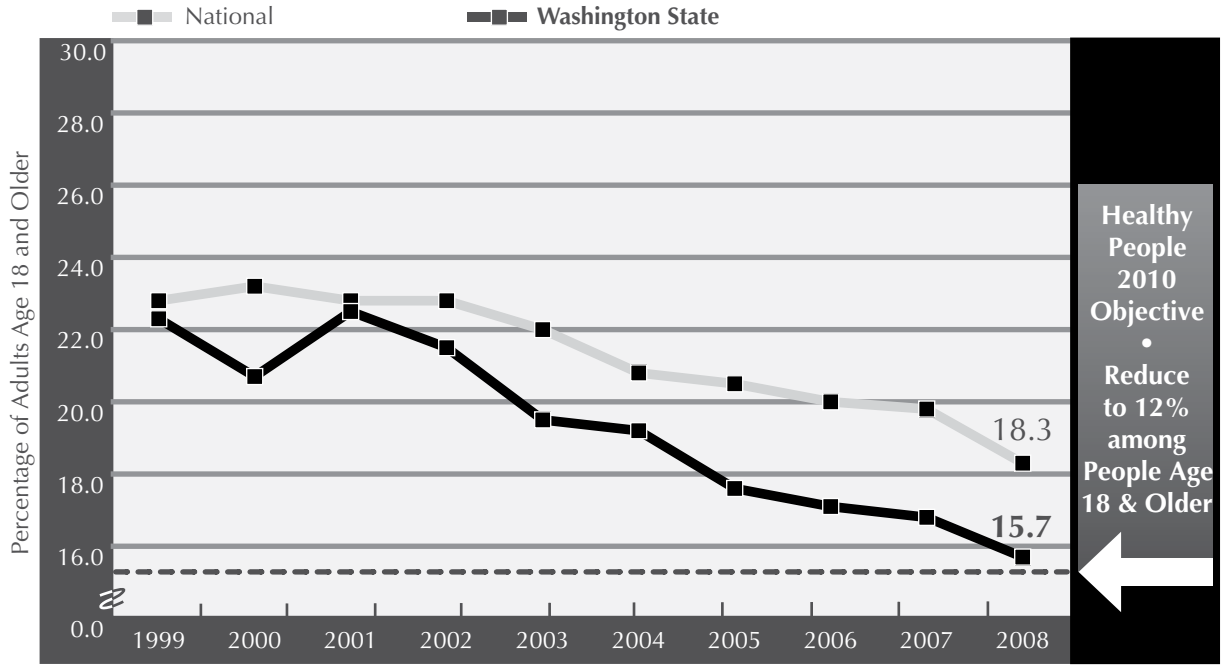
Washington State ranks sixth among states in rate of non-medical use of pain relievers (mostly prescription-type opiates) by those ages 12 and over. It also ranks high among states in users ages 18-25, and 25 and above.[1] Within the state, highest rates of use are in Seattle-King County.[2]

Over the past decade, the use of prescription-type opiates to treat pain has rapidly expanded, with the number of doses legally dispensed almost tripling between 1997-2007. This has created new opportunities for diversion and illicit use, with increased risk of subsequent addiction, overdose hospitalization, and death. In 2007, there were 454 drug-caused deaths in Washington State in which prescription-type opiates were involved.[3]

[1] Office of Applied Studies. *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, 2008.
[2] Office of Applied Studies.*The NSDUH Report: Nonmedical Use of Pain Relievers in Substate Regions: 2004 to 2006*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, 2008.
[3]Center for Health Statistics, Washington State Department of Health, 2008.

NEW/CHANGING TREND

# As a Result of Washington State Tobacco Control Efforts, Smoking Prevalence Among Adults Has Declined 30% Since 2001.




Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

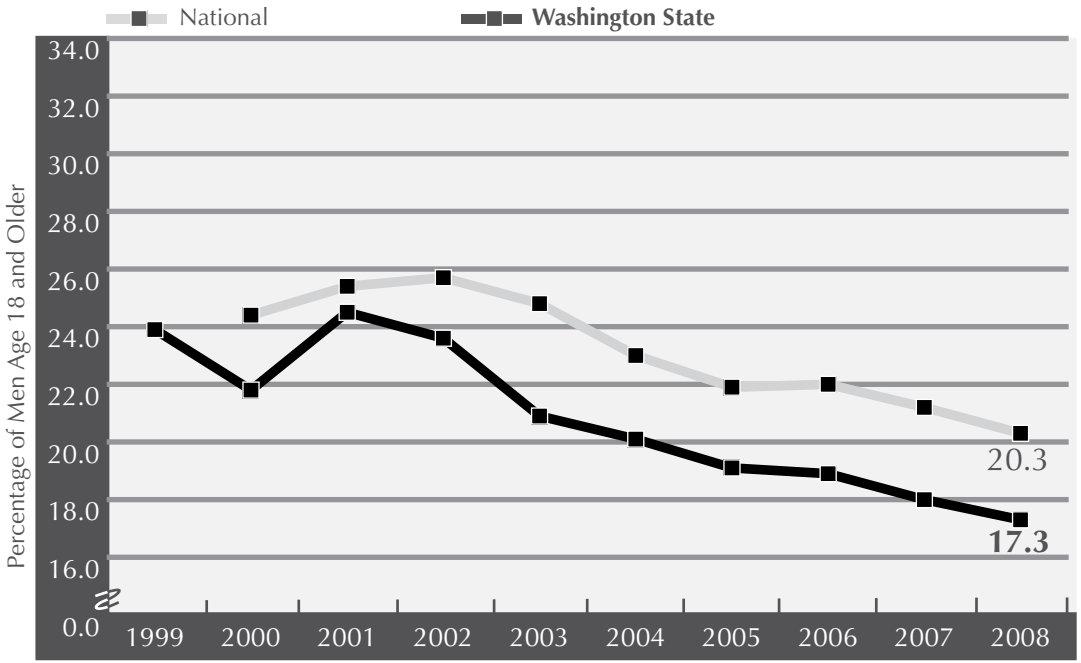
Each year, more than 7,600 Washington residents die prematurely as a result of tobacco use or exposure: 34% of them from lung cancer; 25% from heart disease and stroke; and 25% from chronic lung disease. Expenditures for tobacco-related health care expenses in Washington State were more than $1.5 billion in 2008, $631 for every household. More than 800,000 Washington residents are still addicted to nicotine.

Since the inception of the Washington State Department of Health Tobacco Prevention and Control Program in 2000, the number of adult smokers has declined by 240,000, and by 65,000 among youth. An estimated 80,000 adults will not be subject to a premature tobacco-related death. About 3,000 fewer babies were exposed to cigarette smoke during pregnancy. Secondhand smoke exposure in Washington homes declined by 55%. In 2008, smoking cessation benefits – including pharmaceuticals and nicotine patches – were added to the State Medicaid Plan.



[1] Tobacco Prevention and Control Program. *Progress Report – March 2009.* Olympia, WA: Washington State Department of Health, 2009.
[2] Ibid.

# Smoking Prevalence Among Men in Washington State Continues to Decline.




Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

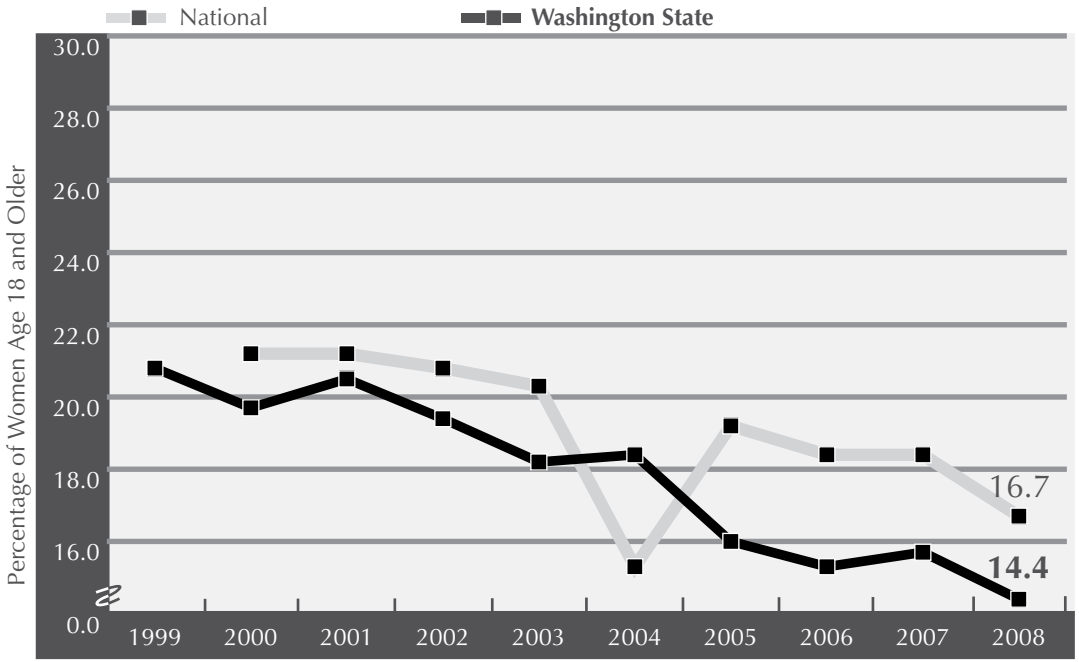
Smoking is closely associated with heart disease, cancer, emphysema, and other respiratory diseases. Since the release of the first Surgeon General's report on smoking and health in 1964, more than ten million Americans have died from smoking-related diseases.[1] Some 7,600 Washington residents die from tobacco-related causes annually.[2]

This graph demonstrates that smoking prevalence among men in Washington State is lower than nationally, and is declining rapidly. Much of this decline can be attributed to the success of the Washington State Department of Health Tobacco Prevention and Control Program, implemented beginning in 2000. However, about 800,000 Washington residents still smoke, and 45 Washington youth begin smoking every day.[3] The Behavioral Risk Factor Surveillance System 2008 Survey indicates that higher smoking prevalence rates are associated with lower incomes, lower levels of educational attainment, African-Americans, and males.[4]

[1] U.S. Department of Health and Human Services. Reducing Tobacco Use: A Report of the Surgeon General. Atlanta, GA: 2000.
[2] Tobacco Prevention and Control Program. *Progress Report – March 2009*. Olympia, WA: Washington State Department of Health, 2009.
[3] Ibid.
[4] National Center for Chronic Disease Prevention & Health Promotion. Behavioral Risk Factor Surveillance System 2008 Prevalence Data. Atlanta, GA: Center for Disease Control and Prevention, 2009.

NEW/CHANGING TREND

# Smoking Prevalence Among Women in Washington State Has Fallen 36% Since 2001.




Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

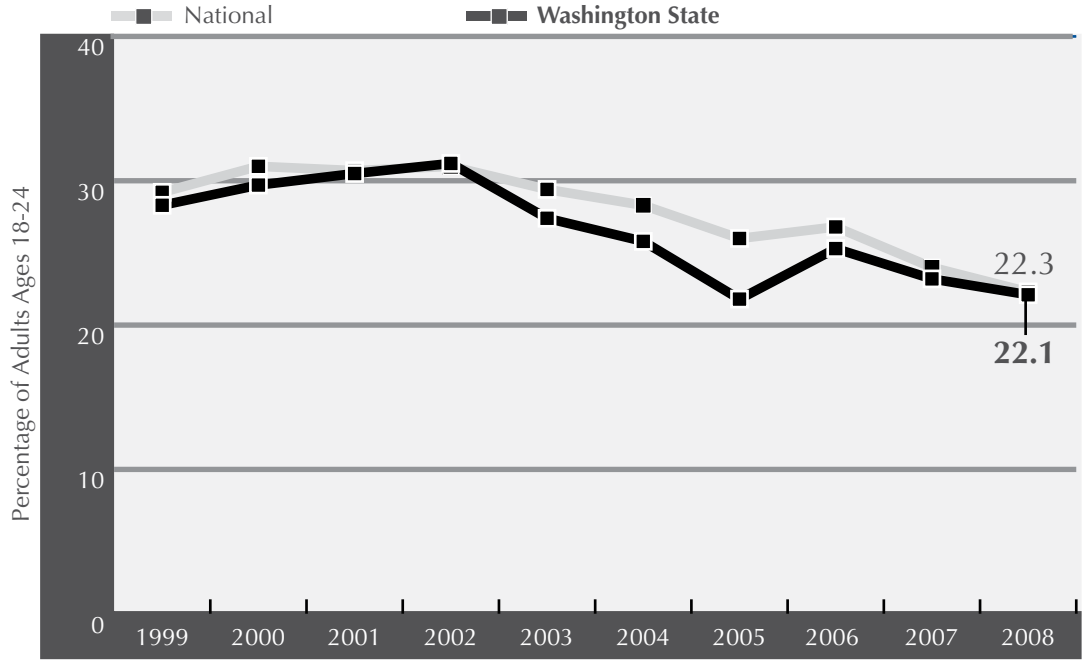
Besides being linked with heart disease, cancer, emphysema, and other respiratory diseases[1], evidence is accumulating that maternal tobacco use is associated with mental retardation and birth defects such as oral clefs[2], and with Sudden Infant Death Syndrome.[3] Smoking during pregnancy is associated with increased risks of miscarriage or stillbirth, and pre-term and low birth weight births.[4]

This graph demonstrates that smoking prevalence among women in Washington State is lower than nationally, and is declining rapidly. Much of this decline can be attributed to the success of the Washington State Department of Health (DOH) Tobacco Prevention and Control Program, implemented beginning in 2000. However, tobacco-related diseases still kill more than 3,000 Washington women every year. In addition, in 2006, about 12% of pregnant women reported smoking in the last three months of pregnancy, and 8,700 babies are born each year to women who smoke during pregnancy. In 2008, the DOH Tobacco Quite Line began offering expanded services specifically to help pregnancy women increase their chances of quitting and remaining tobacco-free after the baby is born.[5]



[1] U.S. Department of Health and Human Services. *Reducing Tobacco Use: A Report of the Surgeon General.* Atlanta, GA: 2004.
[2] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 27-3. Washington, DC: 2000.
[3] Klonoff-Cohen, H. et al. "Effect of Passive Smoking and Tobacco Exposure Through Breast Milk on Sudden Infant Death Syndrome." *Journal of the American Medical Association*, March 8, 1995.
[4] *Reducing Tobacco Use*, op. cit.
[5] Washington State Department of Health, May 2008.

# Smoking Prevalence Among Young Adults Ages 18-24 Has Declined Over the Past Decade.



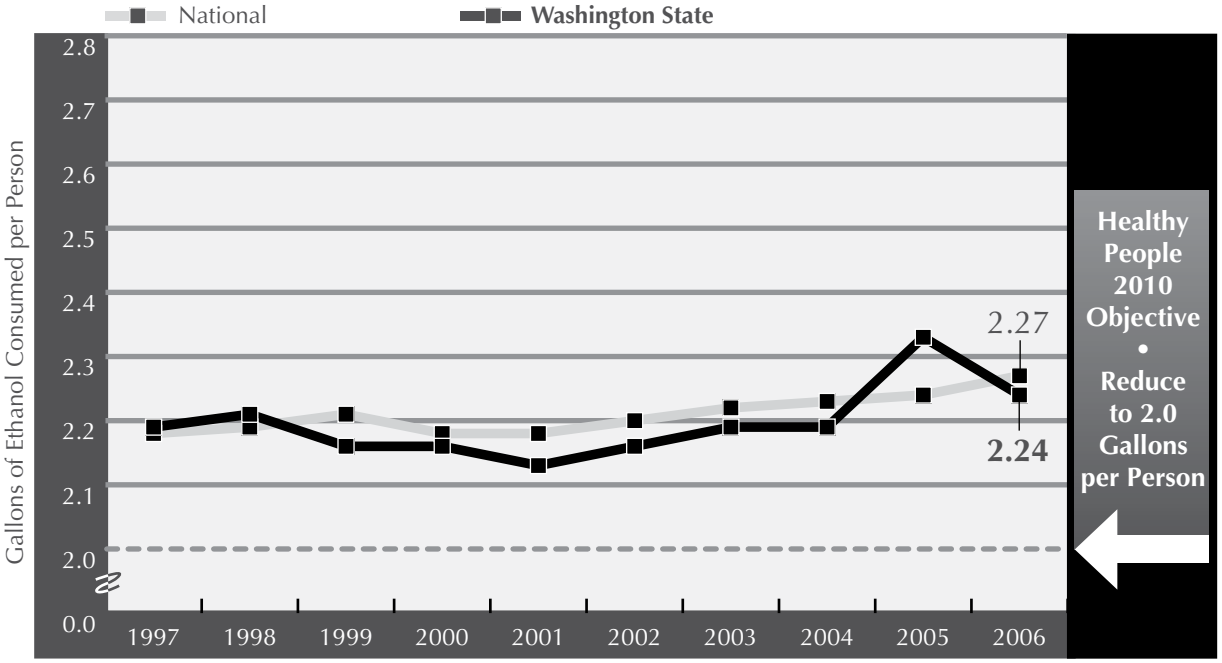

Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Adult smoking peaks among 18-24 year olds, and declines thereafter. Studies indicate that the more funds that states spend on comprehensive tobacco-control programs, the greater the reduction in smoking.[1]

This graph demonstrates that smoking prevalence among young adults in Washington State is lower than nationally, and is declining. Much of this decline can be attributed to the success of the Washington State Department of Health (DOH) Tobacco Prevention and Control Program, implemented beginning in 2000. Since the program's inception, youth smoking rates have been cut approximately in half, the result being there are about 65,000 fewer youth smokers. These declines will result in nearly 13,000 fewer smoking-related deaths. However, there are still more than 800,000 Washington residents addicted to nicotine, with tobacco-related health costs exceeding $1.5 billion annually.[2]

[1] Centers for Disease Control and Prevention. "State-Specific Prevalence of Current Cigarette Smoking Among Adults – United States, 2003." *Morbidity and Mortality Weekly Report* Vol. 53 (44), November 2004.
[2] Tobacco Prevention and Control Program. *Progress Report – March 2009.* Olympia, WA: Washington State Department of Health, 2009.

# Per Capita Alcohol Consumption in Washington State is Similar to the Nation.




Source: LaVallee, R., et al., Surveillance Report #85: Apparent Per Capita Alcohol Consumption: National, State, and Regional Trends, 1970-2006. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism, Division of Epidemiology and Prevention, November 2008.

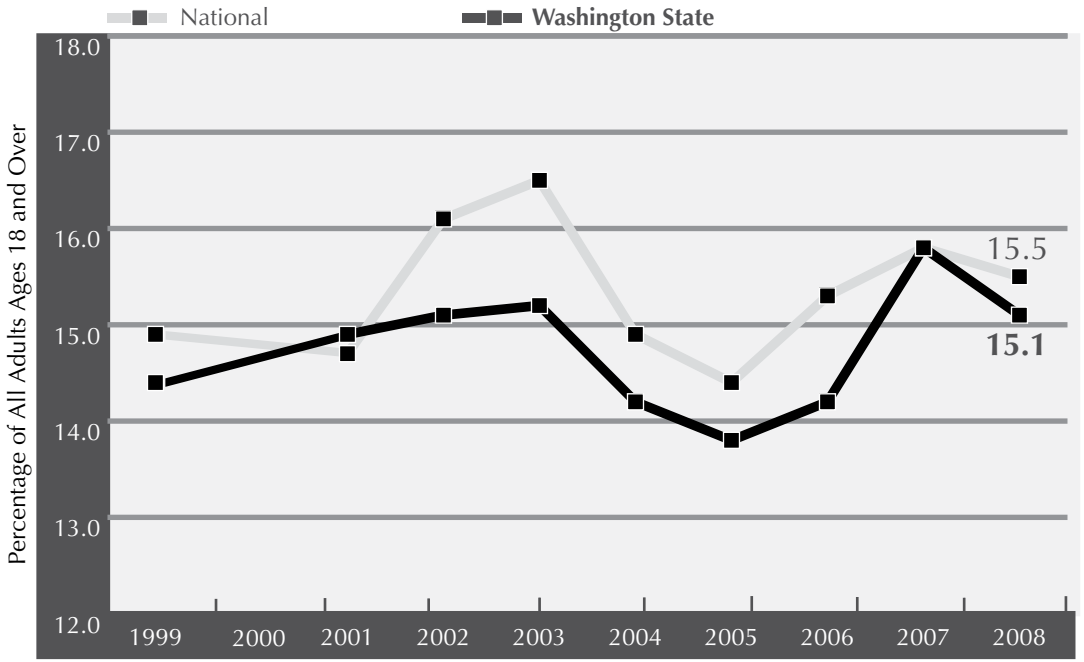
Alcohol is a known human carcinogen, with studies indicating a causal relationship between consumption of alcohol and cancers of the mouth, pharynx, larynx, and esophagus.[1] A 2009 study of more than a million middle-aged women in the United Kingdom found that even small amounts of alcohol were linked with breast, rectum, liver, esophagus, and pharynx cancers, with approximately 13% of these cancers attributed to alcohol use.[2]

Per capita alcohol consumption in Washington State is similar to that of the nation, and has been rising slowly during this decade.



[1] National Toxicology Program. *Report on Carcinogens, Eleventh Edition.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2009.
[2] Allen, N. et al. "Moderate Alcohol Intake and Cancer Incidence in Women. *Journal of the National Cancer Institute* 101(5), 2009.

# Adult Binge Drinking in Washington State is Higher than Three Years Ago.



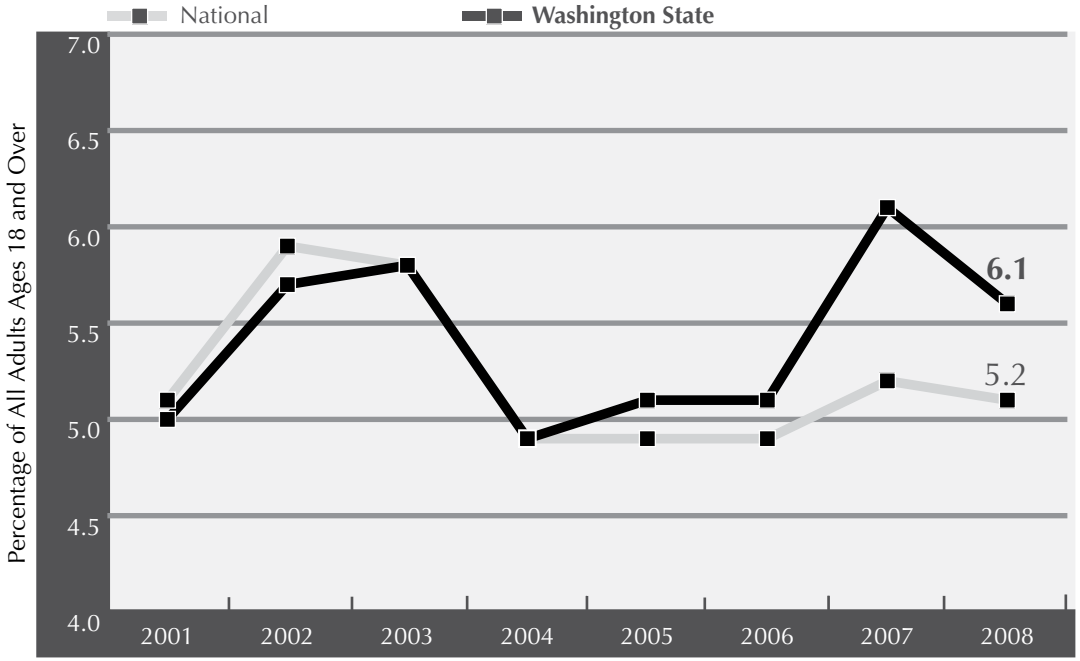

Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

Binge drinking is a particularly dangerous form of alcohol consumption, and is associated with traffic fatalities, accidents, drownings, emergency department admissions, and alcoholism. Binge drinking rates among college students (41% in 2008) are more than twice the rate for all adults, and are associated with increased incidence of unplanned and unprotected sex, alcohol-related sexual assaults, and date rape.[1]

Binge drinking was formerly defined as having five or more alcoholic drinks at one occasion, one or more times in the past month. After several years of research and consensus building, in 2004 the National Institute on Alcohol Abuse and Alcoholism redefined binge drinking as "a pattern of drinking alcohol that brings blood alcohol concentration (BAC) to 0.08 gram percent or above. For the typical adult, this pattern corresponds to consuming five or more drinks (male), or 4 or more drinks (female), in about two hours."[2]

[1] Taskforce on College Drinking, National Advisory Council on Alcohol Abuse and Alcoholism. *A Call to Action: Changing the Culture of Drinking at U.S. Colleges.* Bethesda, MD: U.S. Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism, 2002.
[2] National Institute on Alcohol Abuse and Alcoholism. *NIAAA Newsletter* 2004(3).

# Adult Heavy Drinking Rates in Washington States are Higher than the Nation.




Source: Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

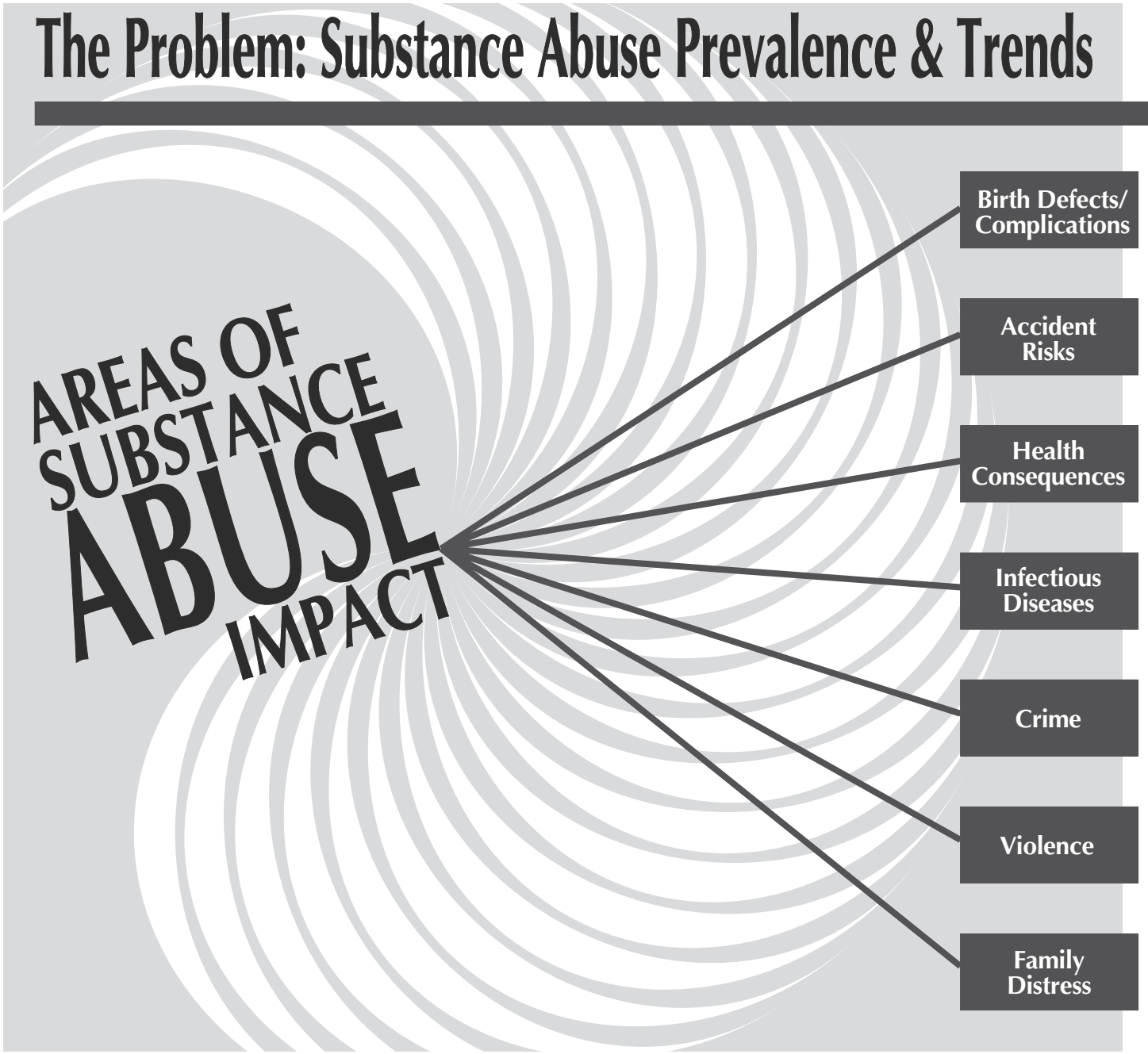
Long-term heavy drinking increases risk for high blood pressure, heart rhythm irregularities, heart muscle disorders (cardiomyopathy), and stroke. It is also linked to cirrhosis and other liver disorders, deaths from traffic crashes, falls, fires, and drowning, worsens outcomes for individuals with hepatitis C, and is associated with homicide, suicide, domestic violence, and child abuse.[1]

The rate of adult heavy drinking in Washington State has risen since 2004. Binge drinking has risen as well.

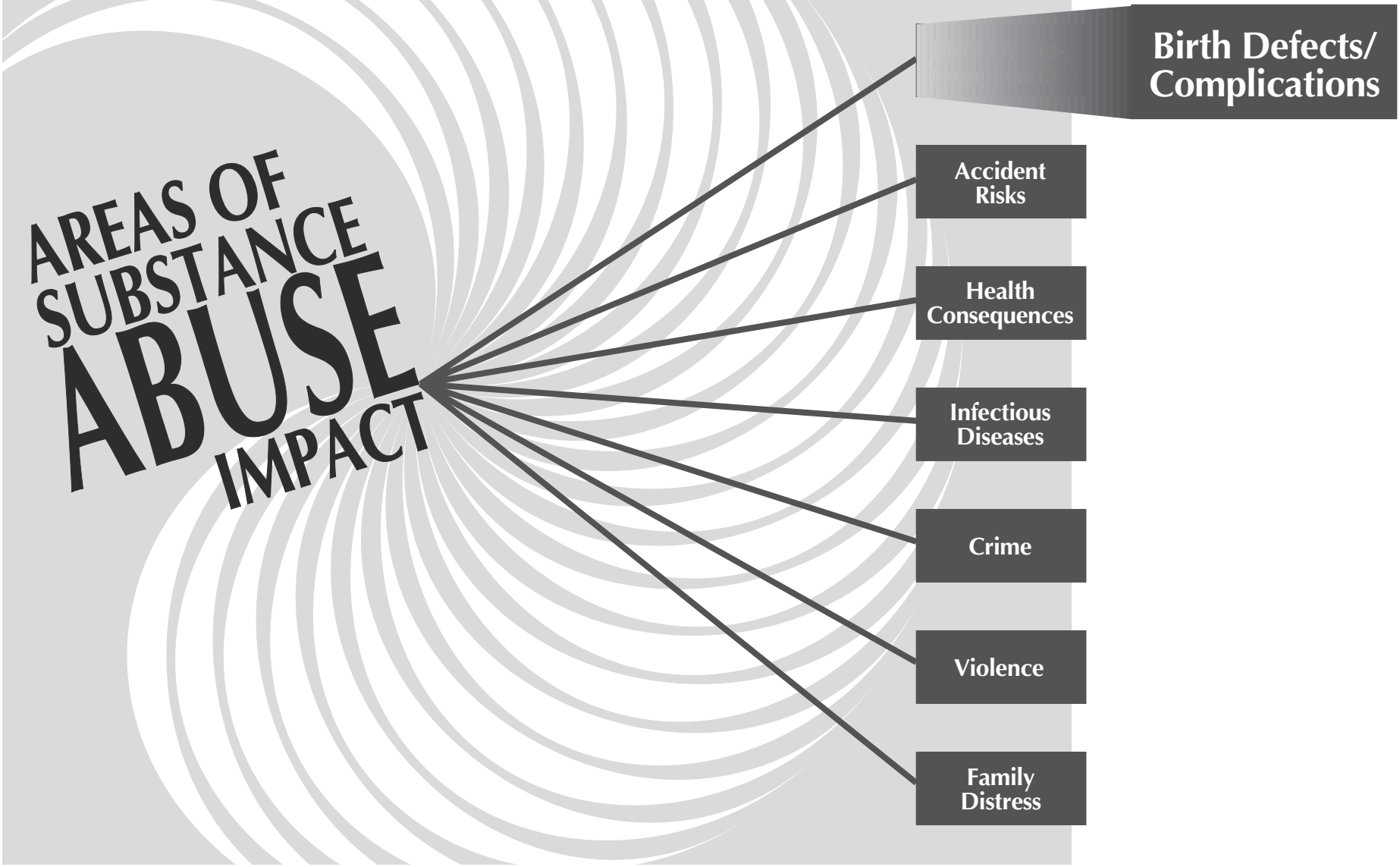


[1] U.S. Department of Health and Human Services. *Health People 2010 (Conference Edition)*, 26-4. Washington, DC: 2000.

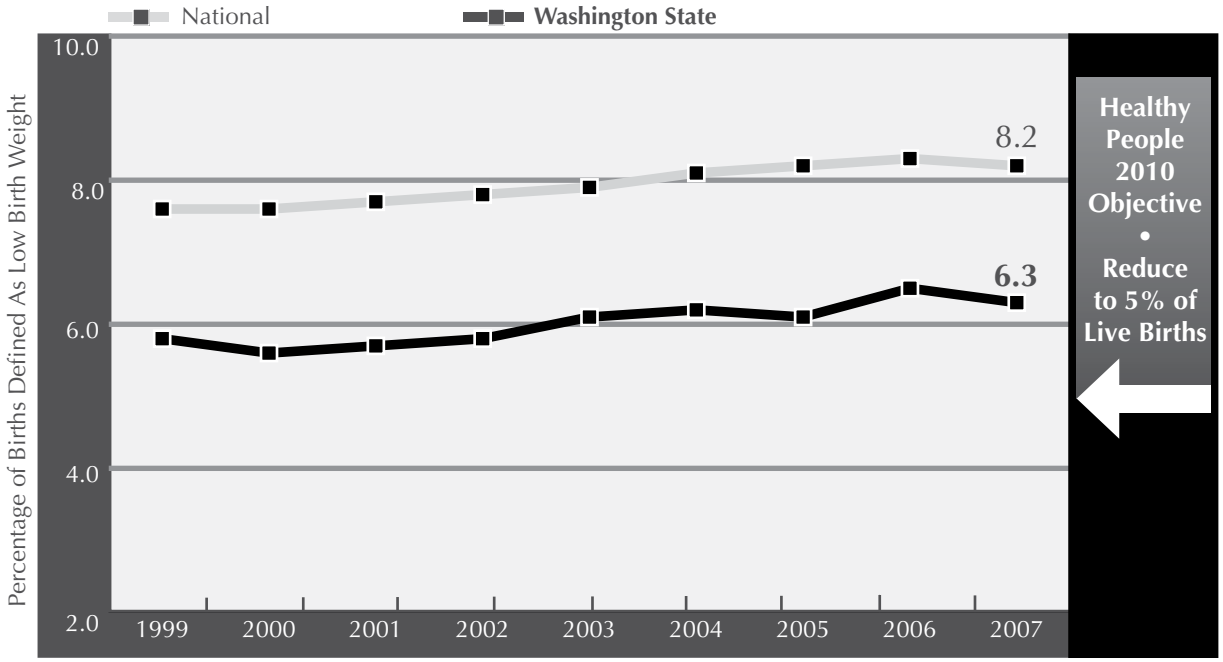
# The Problem: Substance Abuse Prevalence & Trends



# The Problem: Substance Abuse Prevalence & Trends



# In 2007, the Rate of Low Birth Weight Births Rose Significantly in Washington State Fell Slightly.



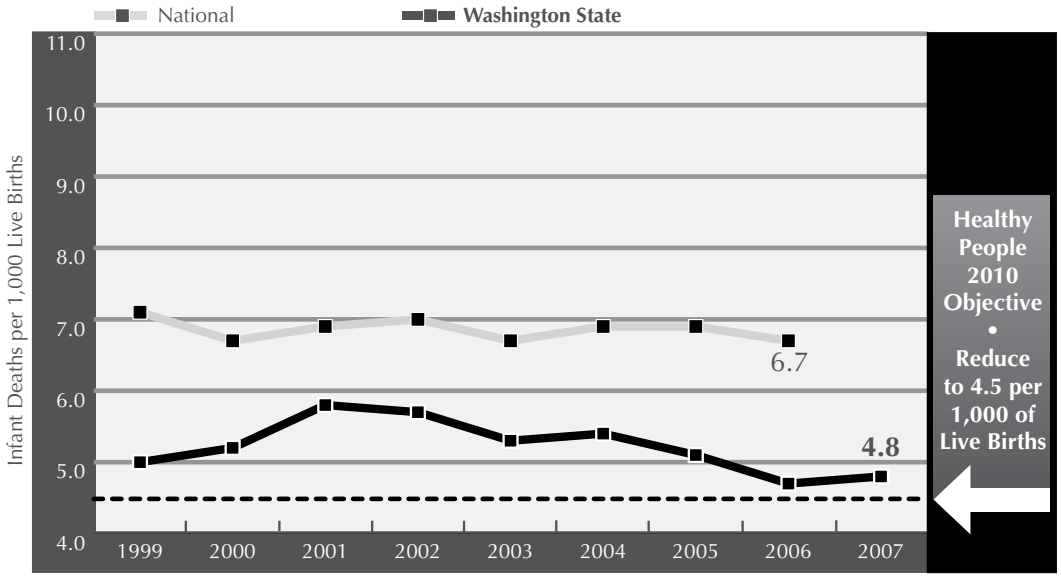

Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Smoking is associated with 20-30% of all low birth weight (LBW) births, as well as being the risk factor most closely associated with neonatal deaths.[1] Low birth weight is also associated with teen births.[2] In 2007, Washington State teen births among those ages 15-17 rose for the second straight year in 2007, by 7.5%.

LBW infants are newborns weighing less than 2,500 grams (5 pounds, 8 ounces) and include those born prematurely and those whose intrauterine growth is retarded. LBW is associated with long-term disabilities, including cerebral palsy, autism, mental retardation, hearing impairments, and other developmental problems.[3] A Washington State study found that substance abusing women who received chemical dependency treatment while pregnant were 34% less likely to give birth to a LBW baby, compared with women who did not receive treatment.[4]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4; 16-34. Washington, DC, 2000.
[2] Hoffman, S. *By the Numbers: The Public Costs of Teen Childbearing.* Washington, DC: The National Campaign to Prevent Teen Pregnancy, 2006.
[2] Ibid.
[3] Cawthon, L. "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

# The Infant Mortality Rate in Washington State is Significantly Lower Than the Nation.




Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

There is a clear association between overall rates of alcohol use during pregnancy and infant mortality rates. Infant mortality rates for children born to mothers on Medicaid in Washington State and identified as substance abusers are more than twice as high as those for infants born to mothers on Medicaid not so identified.[1]

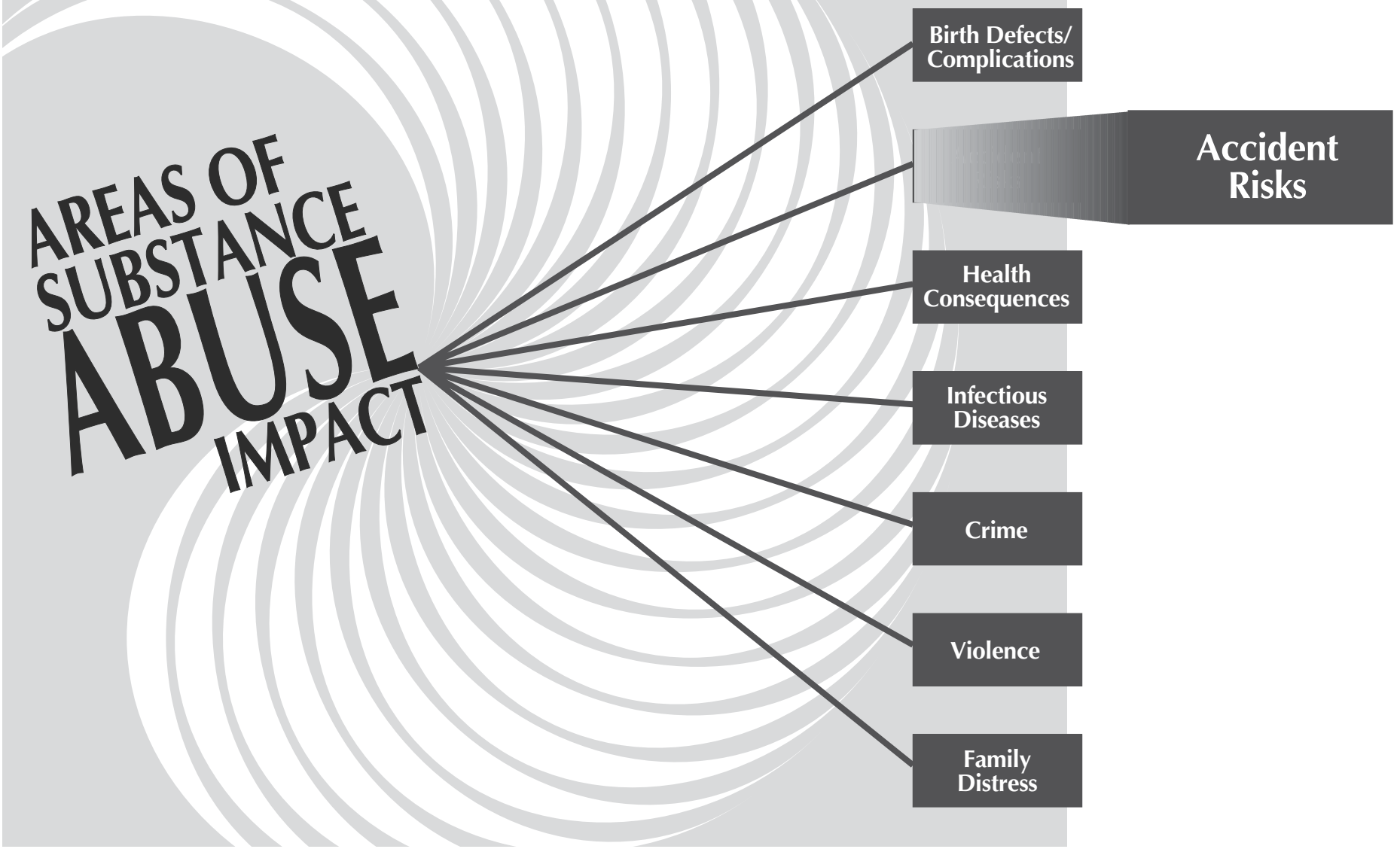
Infant mortality rates represent the number of infants per thousand live births who die within their first year of life. The three leading causes of infant mortality in Washington State in 2007 were perinatal conditions (39.6%) congenital malformations (23.7%), and Sudden Infant Death Syndrome (SIDS, 15.0%).[2] SIDS, the leading cause of post-neonatal death, has been linked with passive smoking in the infant's environment and maternal smoking during the time period of breastfeeding.[3] More recent research suggests an association between prenatal exposure through maternal smoking and alcohol use and adverse development of the brainstem serotonin system, eventually resulting in SIDS.[4]

Washington State has had consistently lower infant mortality rates than the nation. There were 427 infant deaths in Washington State in 2007. SIDS deaths have declined more than 50% since 1995. Advances in medical technology, coupled with public education campaigns (including campaigns to ensure infants are put to sleep on their backs to lower SIDS risk), are given credit for the downward trend.

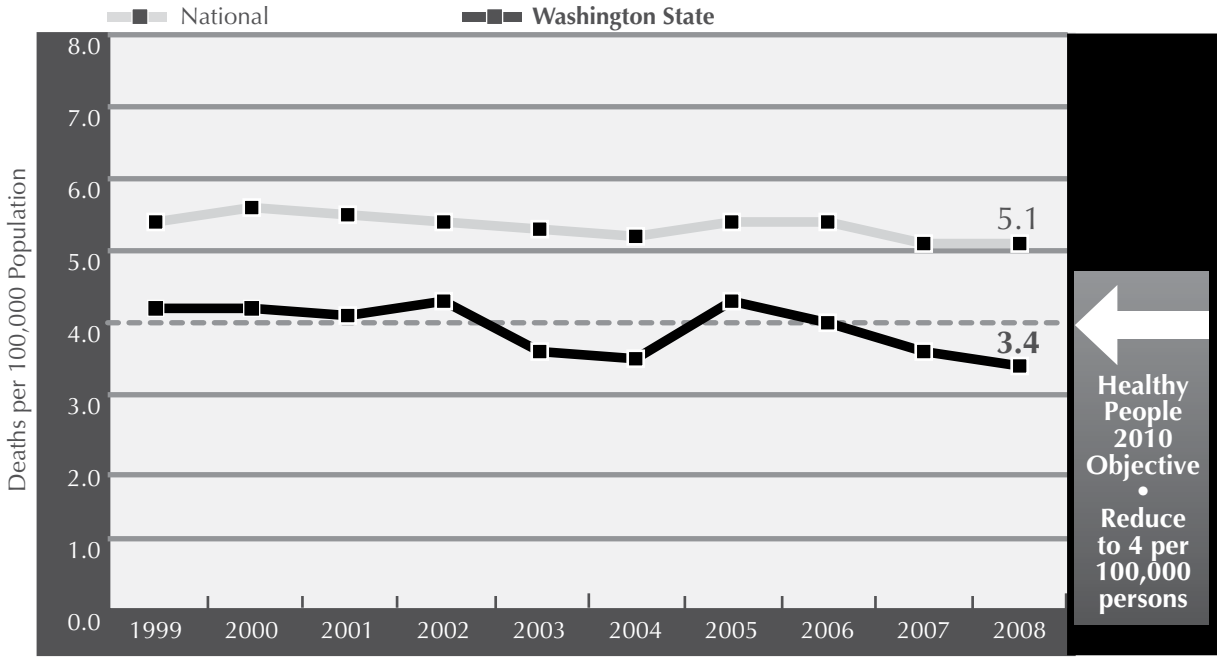


[1] First Steps Database, 1990-1997. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, 1999.
[2] Center for Health Statistics, Washington State Department of Health, 2008.
[3] Klonoff-Cohen, H. et al. "Effect of Passive Smoking and Tobacco Exposure Through Breast Milk on Sudden Infant Death Syndrome." *Journal of the American Medical Association*, 273(10), March 8, 1995.
[4] Paterson, D. et al. "Multiple Brainstem Abnormalities in Sudden Infant Death Syndrome," *Journal of the American Medical Association* 296(17), November 1, 2006.

# The Problem: Substance Abuse Prevalence & Trends



# In 2008, Alcohol-Related Motor Vehicle Fatality Rates in Both Washington State and Nationally Hit Ten-Year Lows.

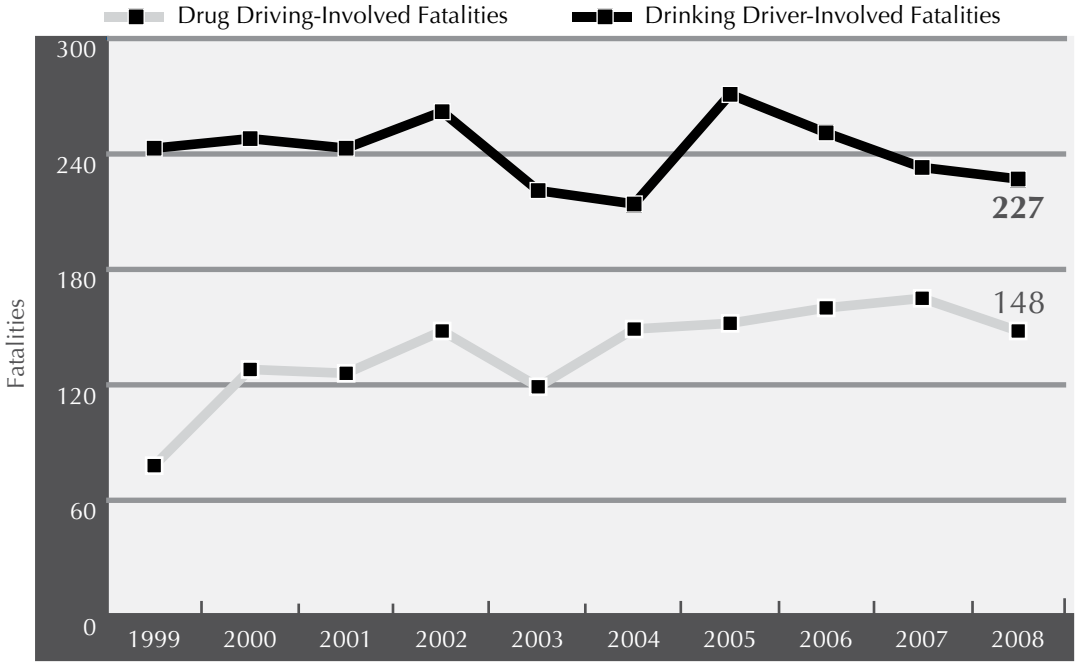



Source: National data from the National Center for Statistics & Analysis, National Highway Traffic Safety Administration. State data from the Fatality Analysis Reporting System (FARS), Washington Traffic Safety Commission.

Enhancements to Washington State's Driving-Under-the-Influence (DUI) statutes, including a lowering of the blood-alcohol concentration (BAC) for a DUI determination from .10% BAC to .08% BAC, went into effect in 1999. However, it should be noted that arrests under DUI statutes are made in a tiny fraction of drinking-and-driving episodes. Nationally, it has been estimated that one arrest is made for driving under the influence for every 772 episodes of driving within two hours of drinking, and for every 88 episodes of driving over the legal limit.[1] Enforcement of existing statutes may play a critical role in reducing morbidity and mortality resulting from alcohol-related motor vehicle crashes.

[1] Zador, P., Krawchuk, S., and Moore, B. "Drinking and Driving Trips, Stops by Police, and Arrests: Analysis of the 1995 National Survey of Drinking and Driving Attitudes and Behavior." Rockville, MD: Estat, Inc., 1997.

# In Washington State, While the Number of Drinking Driver-Involved Fatalities Has Remained Stable, the Number of Drugged Driver-Involved Fatalities Has Been Rising.



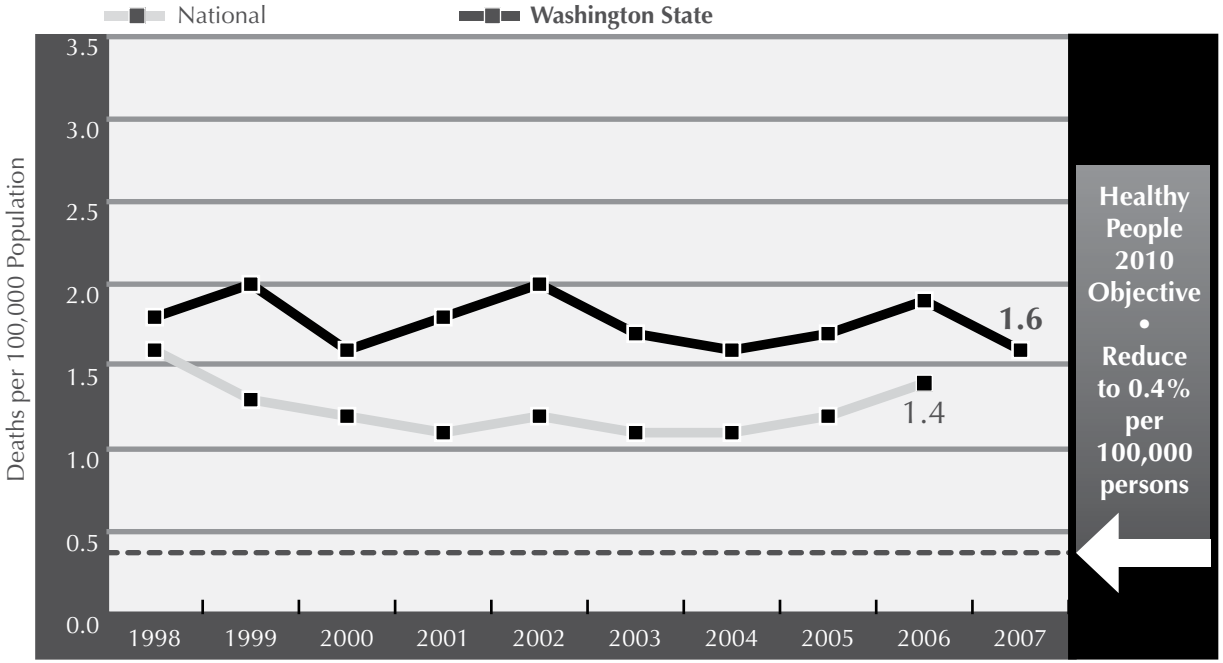

Source: Fatal Accident Reporting System (FARS), Washington Traffic Safety Commission.

Drinking driver-involved fatalities are defined as deaths resulting from a collision in which at least one driver had a positive alcohol test or police reported alcohol involvement. Drugged driver-involved fatalities are deaths resulting from a collision in which at least one driver exhibited a presence of any drug in drug test results. It is likely that some of the increase in drugged driver-involved fatalities is due to better testing and reporting. In 2004-2006, it is estimated that 13.8% of drivers ages 18 and older drove under the influence of alcohol or illicit drugs in the past year.[1]



[1] Office of Applied Studies. *State Estimates of Driving Under the Influence of Alcohol and Illicit Drugs in the Past Year Among Current Drivers Aged 18 or Older: Average of 2004-2006.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.

# Washington State Has a Higher Rate of Deaths Due to Drowning than the Nation.



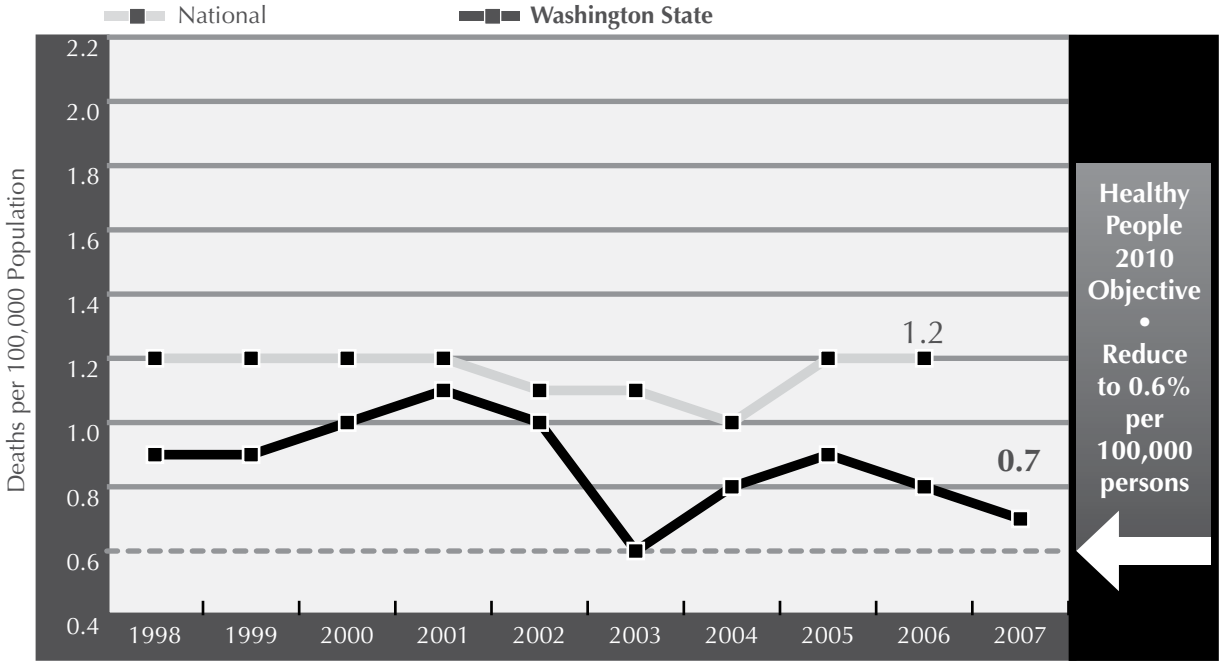

Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

This graph indicates that the rate of drowning deaths in Washington State has been consistently higher than the national rate. There were 103 drowning deaths in 2007 in Washington State, down from 123 in 2006. Nationally, drowning is the second leading cause of injury-related deaths for children and youth ages 1-19.[2]

Alcohol is involved in approximately 50% of deaths associated with water recreation.[1]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 15-40. Washington, DC: 2000.
[2] Ibid.

# The Rate of Death Due to Residential Fires in Washington State is Lower than the Nation.



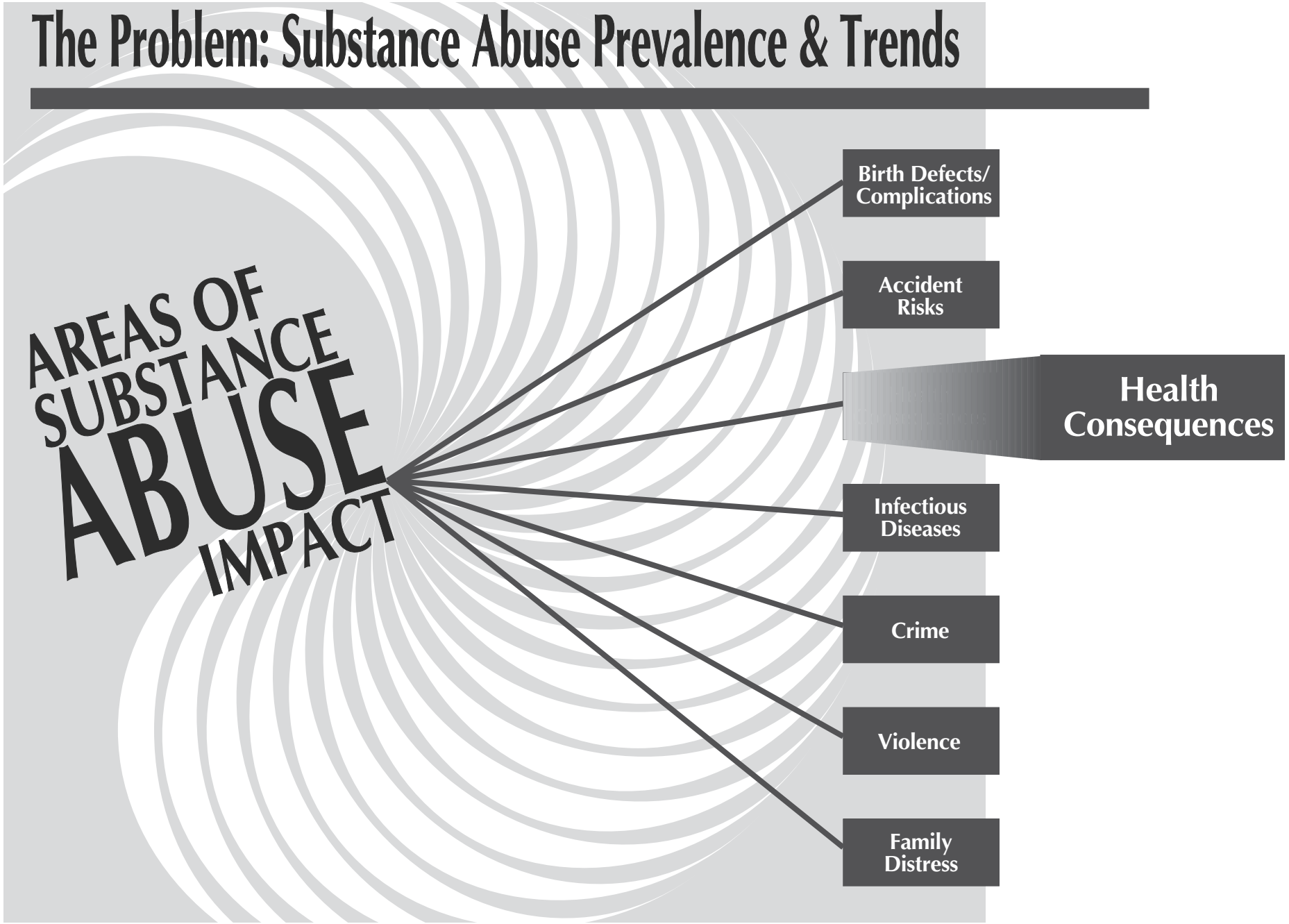

Source: National Data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

This graph indicates that the death rate due to residential fires in Washington State is lower than the nation. There were 46 such deaths in 2007.

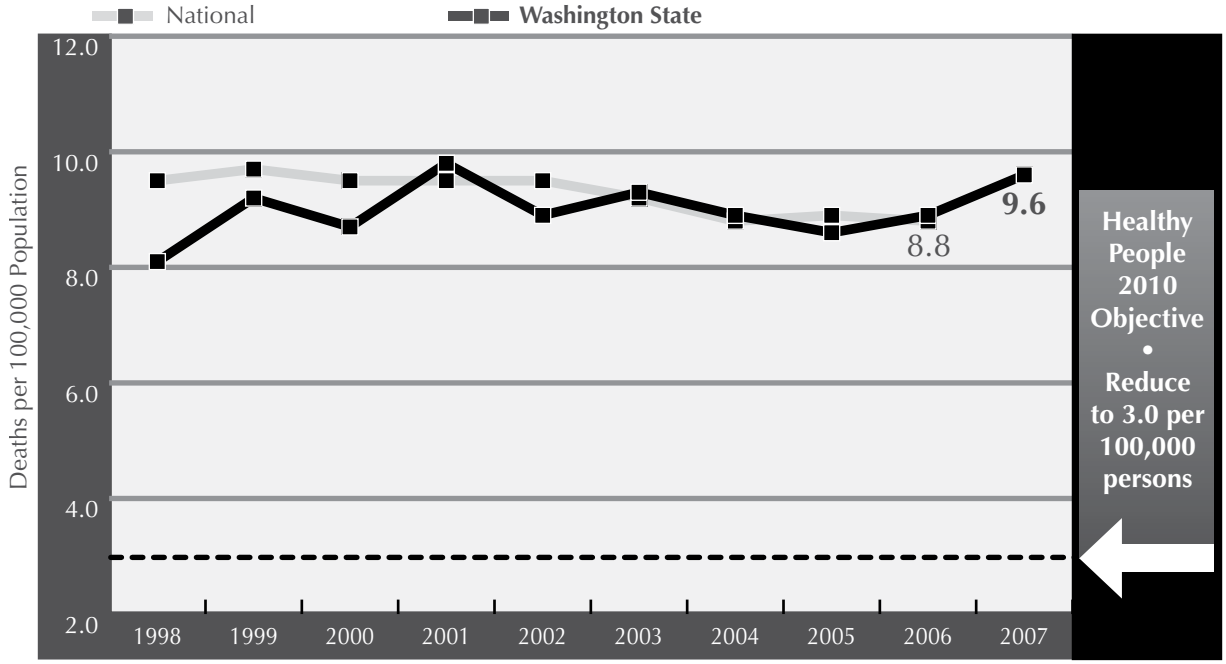
Fires are the second leading cause of unintentional injury death among children. Compared to the total population, children under age four have a fire death rate more than twice the national average. Two-thirds of fire-related deaths and injuries among children under age five occur in homes without working smoke alarms.[1] Tobacco use is the leading cause of residential fire deaths.[2] Smoking causes an estimated 30% of U.S. fire deaths; costs related to fires have fallen in association with lower rates of smoking.[3] Alcohol use contributes to an estimated 40% of residential fire deaths.[4]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 15-35. Washington, DC: 2000.
[2] Centers for Disease Control and Prevention. *Fire Deaths and Injuries.* Atlanta, GA: 2000.
[3] Leistikow, B., et al. "Fire Injuries, Disasters, and Costs from Cigarettes and Cigarette Lights: A Global Overview," *Preventive Medicine* 31:2, 2000.
[4] Smith, G., Branas, C., and Miller, T. "Fatal Nontraffic Injuries Involving Alcohol: A Meta-Analysis," *Annuals of Emergency Medicine* 33(6), 1999.

# The Problem: Substance Abuse Prevalence & Trends



# Sustained Alcohol Consumption is the Leading Cause of Chronic Liver Disease and Cirrhosis Deaths.




Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

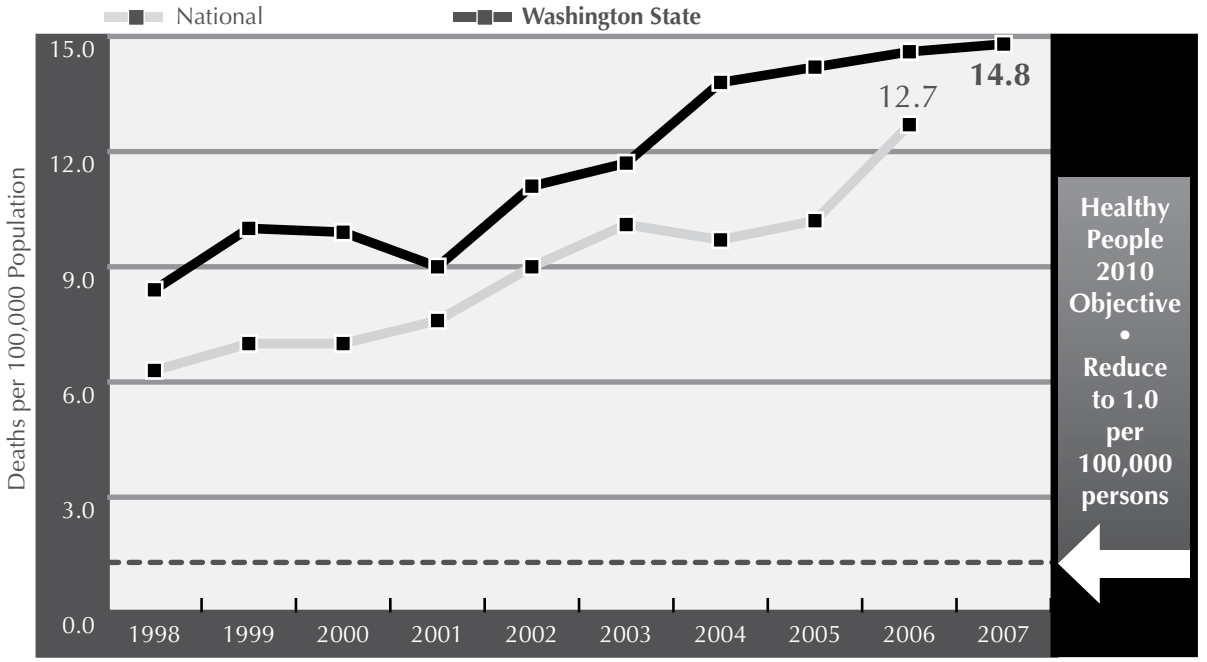
Cirrhosis occurs when healthy liver tissue is replaced with scarred tissue until the liver is unable to function effectively. Sustained heavy alcohol consumption is the leading cause of cirrhosis.[1] Cirrhosis is also associated with hepatitis C and, though less commonly in the United States, with hepatitis B[2], which are often transmitted during intravenous drug use. Once the liver is severely damaged, treatment is often limited to liver transplants.

Little progress has been made in Washington State or nationally in the past decade toward the *Healthy People 2010* target objective. There were 658 chronic liver disease and cirrhosis deaths in Washington State in 2007, representing an 11.4% increase over 2006.

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 26-16. Washington, DC: 2000.
[2] National Digestive Diseases Information Clearinghouse (NDDIC). *Cirrhosis of the Liver*. Bethesda, MD: National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, 2003.

NEW/CHANGING TREND

# The Drug-Induced Death Rate in Washington State is Increasing Rapidly.




Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

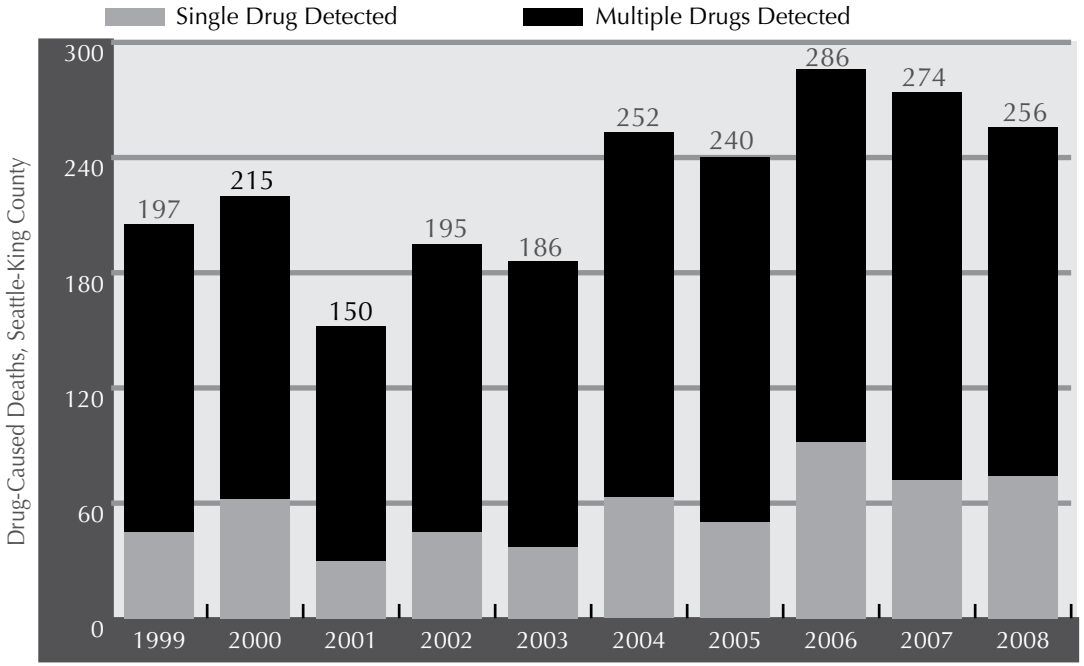
Drug-induced death data provide a direct indication of the high human and social costs of drug use. Causes of death classified as drug-induced include drug psychosis, drug dependence, suicide, and intentional and unintentional poisoning resulting from illicit drug use or overdoses.

This graph indicates that Washington continues to have a higher drug-induced death rate than the nation, with 961 deaths in 2007. Drug-induced deaths have more than doubled since 1997. Much of this increase reflects drug-induced deaths involving the use of prescription-type opiates, which, in Seattle-King County, rose from 29 in 1998 to 153 in 2008.[1]



[1] King County Medical Examiner. In 120 (91.6%) of the 2005 deaths, there were drugs other than prescription opiates in the decedents' systems at time of death.

# In 2008, More than One Drug was Detected in 71% of Drug-Caused Deaths in Seattle-King County.

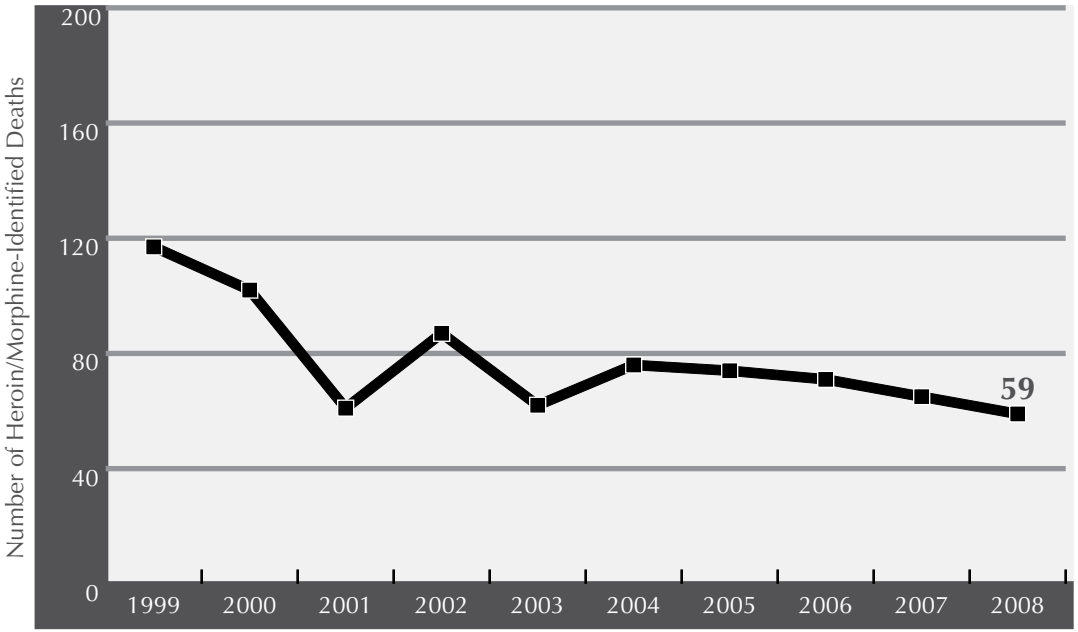



Source: King County Medical Examiner

In the past three years, drug-caused deaths in Seattle-King County have been on the rise. In the overwhelming majority of cases, more than one drug (including alcohol) is detected in the decedent by the Medical Examiner, making it very difficult to determine the role that any single drug played in the death. Of the 256 drug-caused deaths in Seattle-King County in 2008, 71% were multi-drug-involved.

Most individuals who enter publicly funded chemical dependency treatment abuse more than one substance.

# The Number of Drug-Caused Deaths in Seattle-King County in Which Heroin is Involved Has Declined by Half Since 1999.




Source: King County Medical Examiner.

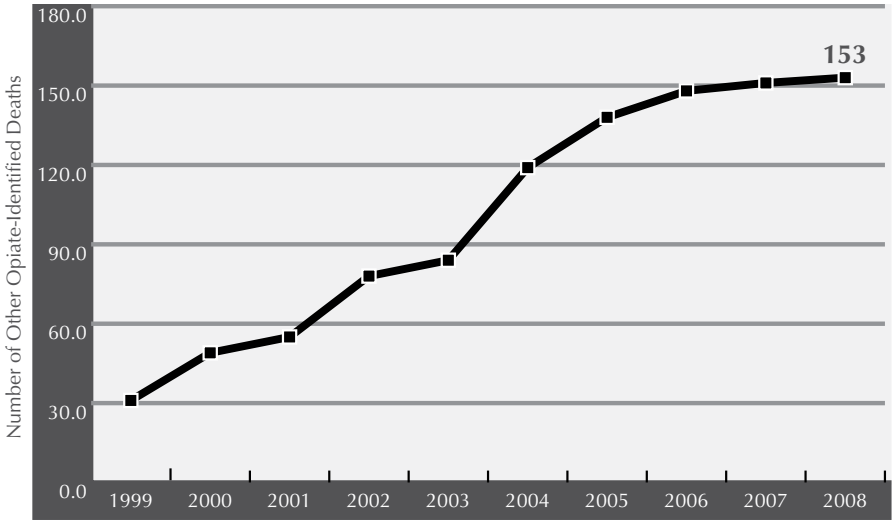
This graph indicates that drug-caused deaths in which heroin/morphine were involved in Seattle-King County have declined by half since 1999, from 117 in 1999 to 59 in 2008.

Much of the decline is likely due to public health measures adopted by city and county governments to address heroin addiction, including a substantial increase in publicly funded treatment admissions. Heroin was the primary drug of abuse for 13.7% of total publicly funded treatment admissions in Seattle-King County during SFY 2008.[1] It should be noted that among the 59 Seattle-King County deaths in 2008 in which heroin was detected in the decedent by the Medical Examiner, 81% had more than one drug (including alcohol) detected, making it very difficult to determine the role that any single drug played in the deaths.



[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

# The Number of Drug-Caused Deaths in Seattle-King County in Which Prescription-Type Opiates* are Involved are More Than Five Times Higher than a Decade Ago.




Source: King County Medical Examiner.

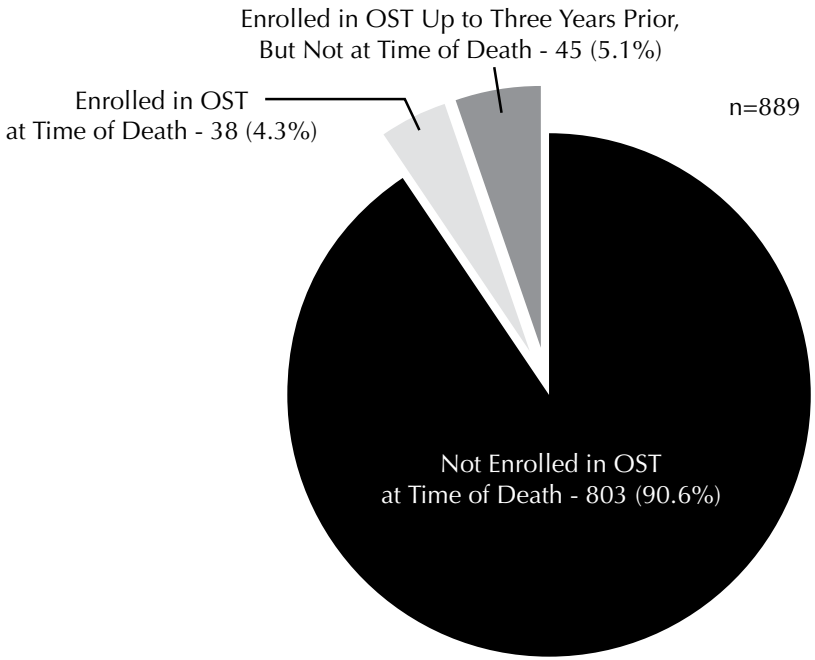
The rise in prescriptions for opiates to treat pain has been very rapid. In Washington State, the number of doses of prescription opiates legally dispensed almost tripled between 1997-2007. In the same time period, the number of grams of active ingredient prescribed of methadone (for pain only) rose 1,042%; Oycodone (including OxyContin) - 500%; Morphine - 223%; and Hydrocodone -166%.[1]

The expanded prescriptive use of opiates has created new opportunities for diversion and illicit use. In Seattle-King County in 2008, 73% of the 3,038 emergency department drug reports for prescription-type opiates were drug-abuse related, up from 54% in 2006.[2] In 2005-2006, Washington State ranked sixth in the nation in the percentage of individuals ages 12 and older using prescription pain relievers for non-medical purposes (6.13%).[3] Highest concentration of illicit use was in Seattle-King County.[4] The number of drug-caused deaths in Seattle-King County in which prescription-type opiates were involved rose from 29 in 1997 to 153 in 2008. It should be noted that among the 153 deaths in 2008 in which prescription opiates were detected in the decedent by the Medical Examiner, 84% had more than one drug (including alcohol) detected, making it very difficult to determine the role that any single drug played in the deaths. SSRI anti-depressants were found in 36% of the prescription-type opiate deaths, and benzodiazepines in 32% of them.

**Defined as opiates other than heroin or morphine. These include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, and propoxyphene.*

[1] Drug Enforcement Administration, 2007.
[2] Office of Applied Studies. Drug Abuse Warning Network (DAWN): Estimates of Drug-Related Emergency Department Visits: Seattle Nonmedical Use of Pharmaceuticals. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.
[3] Office of Applied Studies. *State Estimates of Substance Use from the 2005-2006 National Surveys on Drug Use and Health*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.
[4] Office of Applied Studies. *THE NSDUH Report: Nonmedical Use of Pain Relievers in Substate Regions: 2004 to 2006*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008

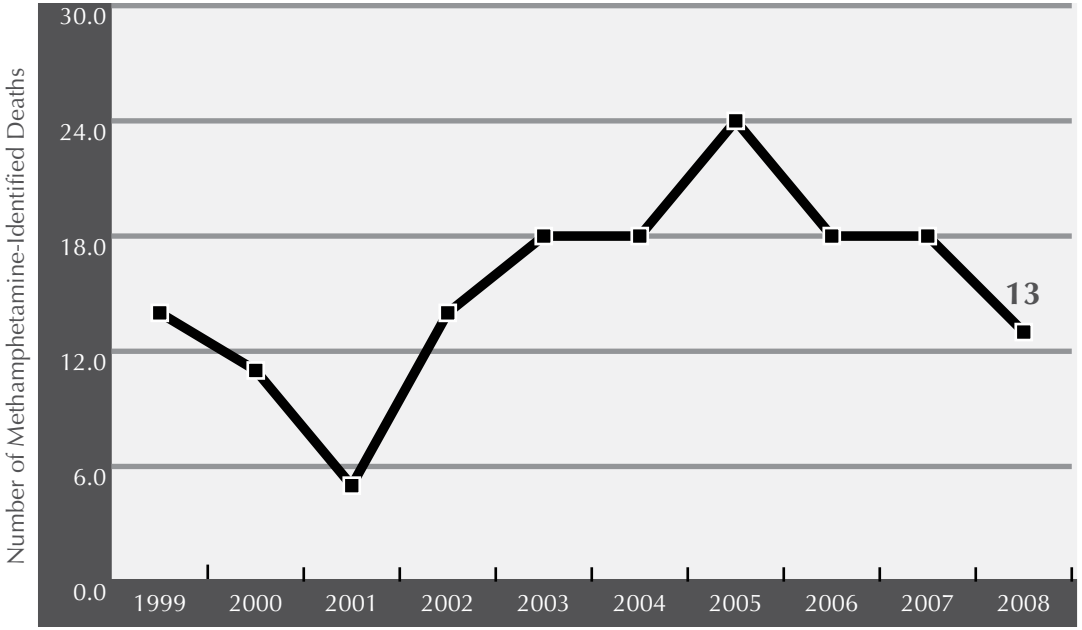
# In 2005-2007, Only 4% of Individuals Whose Deaths were Drug-Caused and in Which Methadone was Detected were Enrolled in Opiate Substitution Treatment (OST) Programs at Time of Death.




Source: Center for Health Statistics, Washington State Department of Health; Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, 2009.

Of the 889 individuals who died from drug-related causes and who had methadone in their systems at time of death, only 38 were enrolled in opiate substitution treatment programs at time of death. Virtually all of them had other drugs (including alcohol) in their systems at the same time, making it very difficult to determine the role that any single drug played in their deaths. Given the available data, and the strict safeguards that are in place, it seems unlikely that diversion of methadone from opiate substitution treatment programs plays a significant role in drug-related mortality in Washington State.

# The Number of Drug-Caused Deaths in Seattle-King County in Which Methamphetamine is Involved is Now Declining.

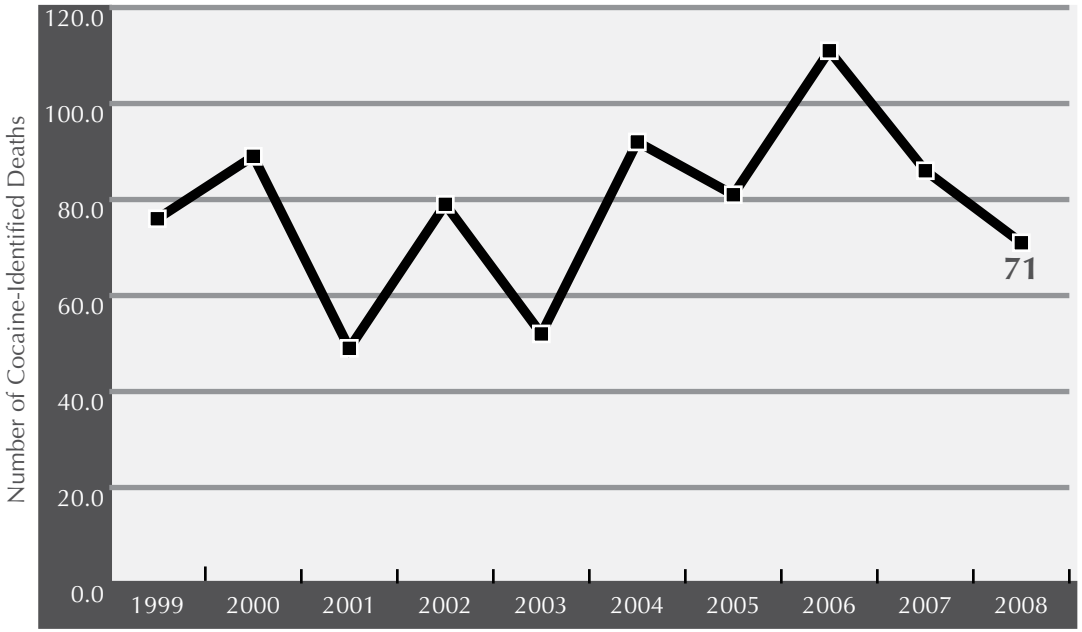



Source: King County Medical Examiner

According to the Northwest High Intensity Drug Trafficking Area (NW HIDTA), methamphetamine no longer poses the greatest threat among illicit substances in Washington State, now ranking below powder cocaine, marijuana, and heroin.[1] Seattle emergency department visits related to the misuse or abuse of methamphetamine declined from 4,217 in 2005, to 2,608 in 2007, representing a 38% decline.[2] Statewide, there has been a significant drop in the number of methamphetamine laboratories and dumpsites report, and in the number of prenatal methamphetamine exposure admissions at the Pediatric Interim Care Center (from 46 infants in 2007, to 27 in 2008, representing a 41% decrease). NW HIDTA believes that methamphetamine availability is decreasing, largely as a result of successful law enforcement efforts, in combination with state and federal controls on precursor chemicals used in drug manufacture.[3]

[1] Northwest High Intensity Drug Trafficking Area. *Threat Assessment and Strategy for Program Year 2010*. Seattle, WA: 2009.
[2] Office of Applied Studies, Drug Abuse Warning Network (DAWN): Estimates of Drug-Related Emergency Department Visits: Seattle All Misuse/Abuse. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.
[3] *Threat Assessment and Strategy*, op. cit.

# The Number of Drug-Caused Deaths in Seattle-King County in Which Cocaine is Involved Has Declined Since 2006.



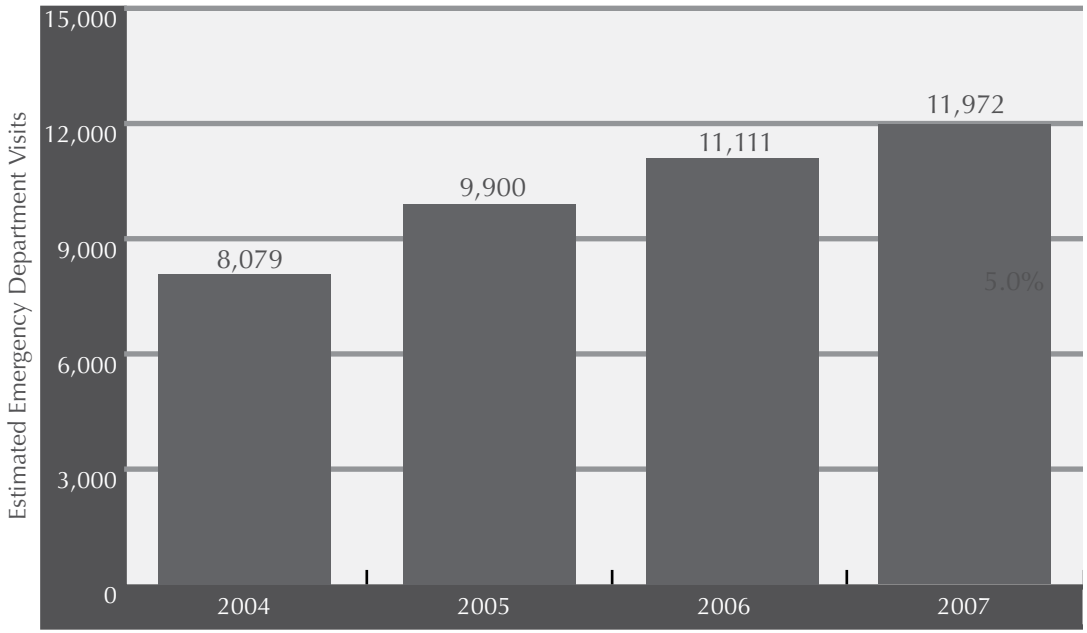

Source: King County Medical Examiner.

According to the Northwest High Instensity Drug Trafficking Area, powder cocaine now poses the greatest threat among illicit substances in Washington State, supplanting methamphetamine.[1] African-Americans represents 21% of all decedents for whom cocaine was present (compared with all drugs, where African-Americans represent only 10% of the total). King County adult treatment admissions where the primary substance of abuse is cocaine doubled between SFY 2004 and SFY 2008, from 995 to 1,906 admissions, with large increases among those agaes 18-25 and 40 and older.[2] Seattle emergency department visits related to the misuse or abuse of cocaine increased from 8,079 in 2004, to 11,972 in 2007, representing a 48% increase.[3]



[1] Northwest High Intensity Drug Trafficking Area. *Threat Assessment and Strategy for Program Year 2010*. Seattle, WA: 2009.
[2] Treatment and Assessment Report Generation Tool (TARGET). Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.
[3] Office of Applied Studies, Drug Abuse Warning Network (DAWN): Estimates of Drug-Related Emergency Department Visits: Seattle All Misuse/Abuse. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.

# Seattle Emergency Department Visits Related to Cocaine Use Increased by 48% Between 2004-2007.

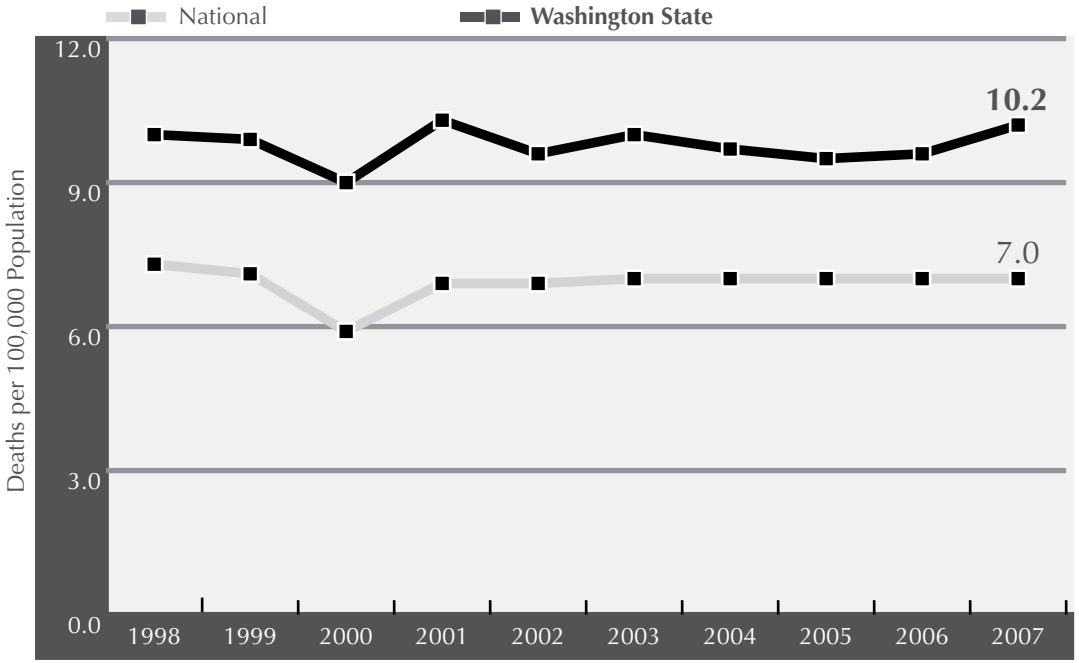



Source: Office of Applied Studies, Drug Abuse Warning Network (DAWN): Estimates of Drug-Related Emergency Department Visits: Seattle All Misuse/Abuse. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.

In Seattle, there are consistently more emergency department visits related to cocaine than for any other illicit drug or for prescription-type opiates, and the number is rising. Adult treatment admissions have climbed steadily to their highest level in at least a decade, with large increases in the numbers of clients aged 18-25 and 40 and older.[1] Powder cocaine is now considered the greatest illicit drug threat to Washington State.[2]

[1] Banta-Green, C., et al. *Recent Drug Trends in the Seattle-King County Area 2008* .Seattle, WA: Community Epidemiology Work Group, 2009.
[2] Northwest High Intensity Drug Trafficking Area. *Threat Assessment and Strategy for Program Year 2010*. Seattle, WA: 2009.

# Washington State Has a Higher Alcohol-Induced Death Rate than the Nation.




Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

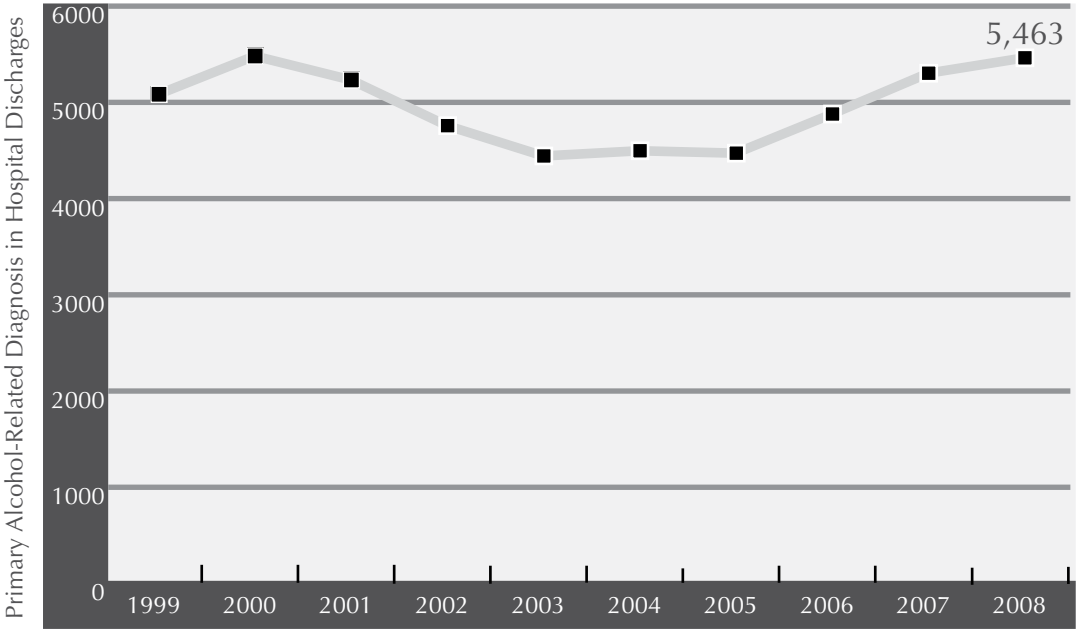
The alcohol-induced death rate provides a direct indication of the high human and social costs of alcohol use. Alcohol is a known human carcinogen, with studies indicating a causal relationship between consumption of alcohol and cancers of the mouth, pharynx, larynx, and esophagus.[1] A 2009 study of more than a million middle-aged women in the United Kingdom found that even small amounts of alcohol were linked with breast, rectum, liver, esophagus, and pharynx, with approximately 13% of these cancers attributed to alcohol use.[2] Long-term heavy drinking increases risks for high blood pressure, heart rhythm irregularities, heart muscle disorders (cardiomyopathy), and stroke. It is also linked to cirrhosis and other liver disorders, deaths from traffic crashes, falls, fires, and drowning, worsens outcomes for individuals with hepatitis C, and is associated with homicide, suicide, domestic violence, and child abuse.[3]

This graph indicates that Washington State has had a consistently higher alcohol-induced death rate than the nation. There were 701 alcohol-induced deaths in Washington State in 2007, representing an 8.3% increase over 2006,



[1] National Toxicology Program. *Report on Carcinogens, Eleventh Edition.* Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2009.
[2] Allen, N. et al. "Moderate Alcohol Intake and Cancer Incidence in Women." *Journal of the National Cancer Institute* 101(5), 2009.
[3] U.S. Department of Health and Human Services. *Health People 2010 (Conference Edition)*, 26-4. Washington, DC: 2000.

# The Number of Acute Care Hospital Discharges in Washington State in Which There was a Primary Alcohol-Related Diagnosis is Increasing.




Source: Comprehensive Hospital Abstract Report System (CHARS), Washington State Department of Health, 2009.

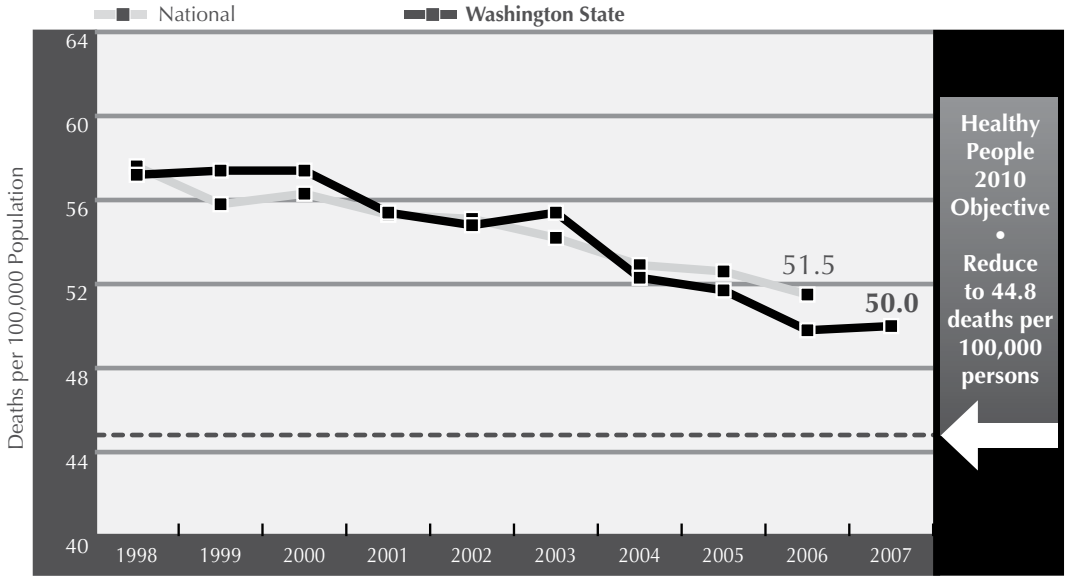
Patients discharged with primary alcohol-related diagnoses from acute care hospitals have been diagnosed with principal alcohol-related conditions such as alcohol psychoses, alcohol dependence syndrome, nondependent abuse of alcohol, and chronic liver disease and cirrhosis. These diagnoses do not include alcohol-related trauma such as injuries from motor vehicle crashes or discharges associated with maternity stays. When discharges with primary or secondary alcohol-related diagnoses are added together, there were 12,582 such discharges in Washington State in 2008.

With a grant from the federal Substance Abuse and Mental Health Services Administration from 2004-2008, the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) program provided screening and brief interventions related to substance abuse in nine hospital emergency departments, and referrals to brief therapy or treatment when appropriate. Among high-risk users of alcohol seen in hospital emergency departments under WASBIRT, days of binge drinking per month declined 63% for those who received only a brief intervention, and 84% for those who received a brief intervention plus brief therapy and/or chemical dependency treatment.[1]



[1] Estee, S., eet al. *Use of Alcohol and Other Drugs Delined Among Emergency Department Patients Who Received Brif Interventions for Substance Use Disorders Through WASBIRT* – Preliminary Report. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2007.

# The Lung Cancer Death Rate in Washington State Has Been Declining.



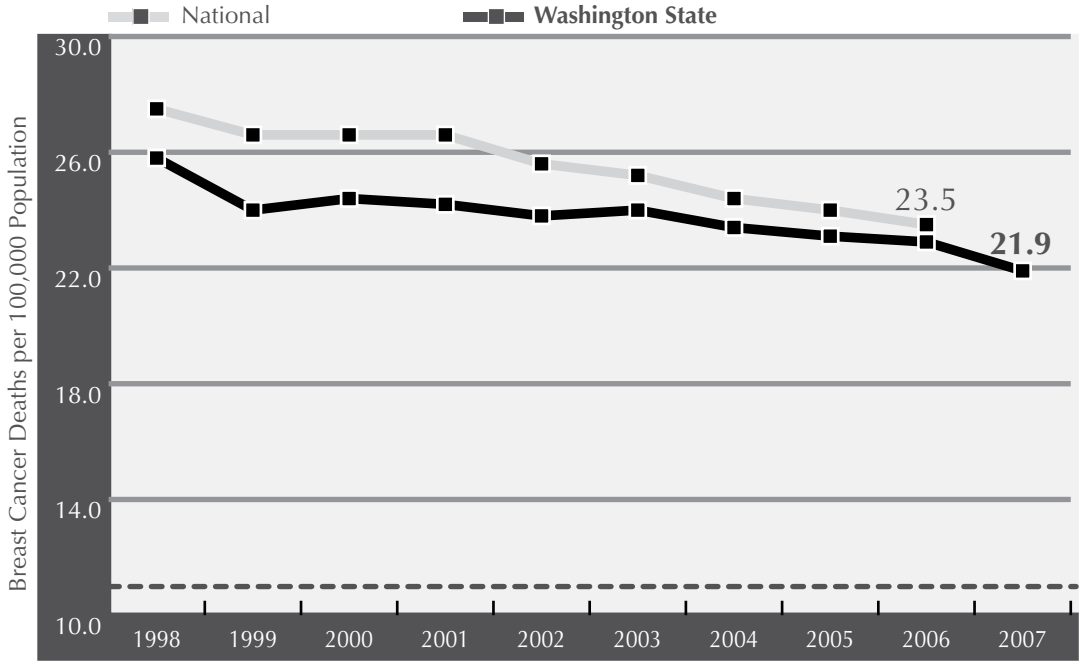

Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Lung cancer is the most common category of U.S. cancer mortality, accounting for 30% of all cancer deaths among males, and 26% among females.[1] The vast majority of lung cancer cases are attributable to cigarette smoking. The risk of developing lung cancer is 23 times higher in male smokers and 13 times higher in female smokers compared to lifetime non-smokers.[2] Among males, the lung cancer death rate has been dropping since 1991. However, death rates for women are now more than twice that of 30 years ago.[3] Secondhand smoke causes approximately 3,000 lung cancer deaths among U.S. nonsmokers every year.[4]

Tobacco is the leading preventable cause of death in Washington State, and kills approximately 7,600 Washington residents each year. It costs every Washington household an estimated $631 per year in public and private expenditures for smoking-related health care, with tobacco-related health care costs at $1.5 billion annually.[5] In 2008, 15.7% of Washington adults were current smokers, representing a 29.9% drop since 1999.[6]

[1] American Cancer Society, 2009.
[2] Office on Smoking and Health. *The Health Consequences of Smoking – A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2004.
[3] National Center for Health Statistics. *U.S. Mortality Data 1960-2005*. Rockville, MD: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2008.
[4] *Health Consequences of Smoking*, op. cit.
[5] Tobacco Prevention and Control Program. *Progress Report – March 2009*. Olympia, WA: Washington State Department of Health, 2009.
[6] Behavioral Risk Factor Surveillance System, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, 2009.

# Even Low Levels of Alcohol Consumption are Linked to Breast Cancer.



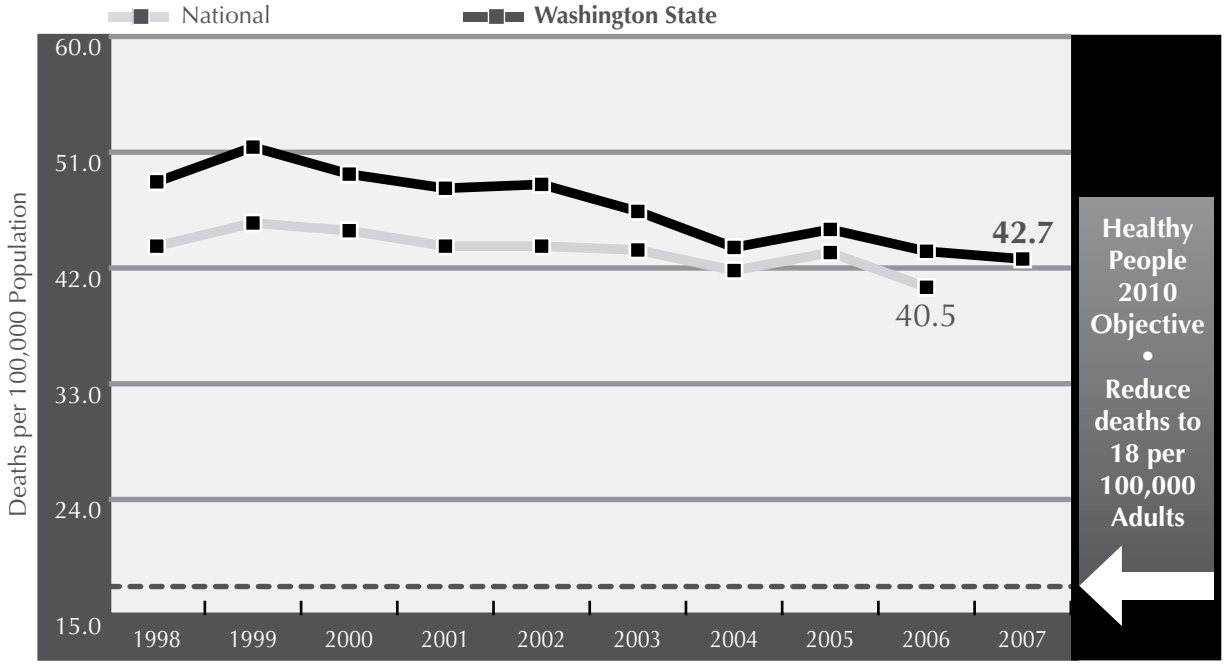

Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Alcohol is a known human carcinogen, with earlier studies indicated a causal relationship between consumption of alcohol and cancers of the mouth, pharynx, larynx, and esophagus.[1] A 2009 study of more than a million middle-aged women in the United Kingdom found that even small amounts of alcohol were linked with breast cancer, with approximately 13% of these cancers attributed to alcohol use.[2]

Breast cancer mortality rates in Washington State have been declining. There were 805 such deaths (including ten men), in 2007.[3]

[1] National Toxicology Program. *Report on Carcinogens, Eleventh Edition*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 2009.
[2] Allen, N. et al. "Moderate Alcohol Intake and Cancer Incidence in Women. *Journal of the National Cancer Institute* 101(5), 2009.
[3] Center for Health Statistics. Olympia, WA: Washington State Department of Health, 2009.

# The Death Rate in Washington State from Chronic Lower Respiratory Disease is Slightly Higher than the Nation.



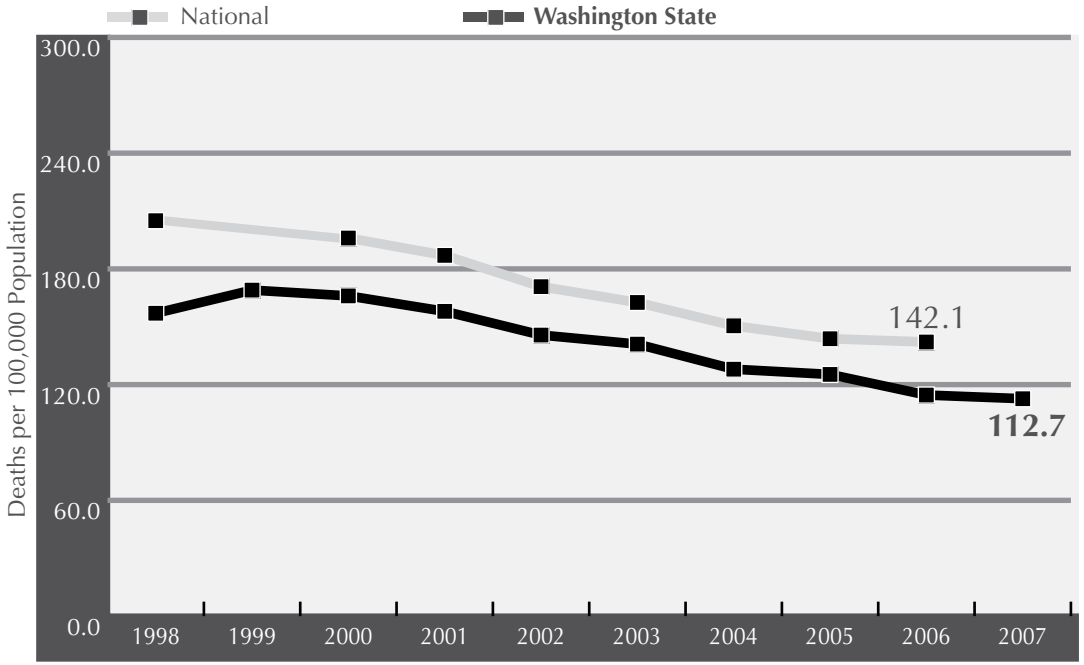

Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Chronic lower respiratory disease (formerly known as chronic obstructive pulmonary disease) occurs most often in people over age 65. Between 80-90% of cases are attributable to cigarette smoking.[1]

This graph indicates that the mortality rate from chronic lower respiratory disease in Washington State is slightly higher than nationally. Chronic lower respiratory disease includes chronic bronchitis and emphysema, both of which are characterized by irreversible airflow obstruction. Both conditions often exist together.[2] There is clear evidence that smoking cessation relieves symptoms and slows the progression of chronic lower respiratory disease, reduces the risk of lung and other cancers, and increases life expectancy.[3]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 24-8. Washington, DC: 2000.
[2] *Ibid.*
[3] Rigotti, N. "Treatment of Tobacco Use and Dependence," *New England Journal of Medicine* 346(7), February 14, 2002.

# The Ischemic Heart Disease Death Rate in Washington State is Lower than the Nation.

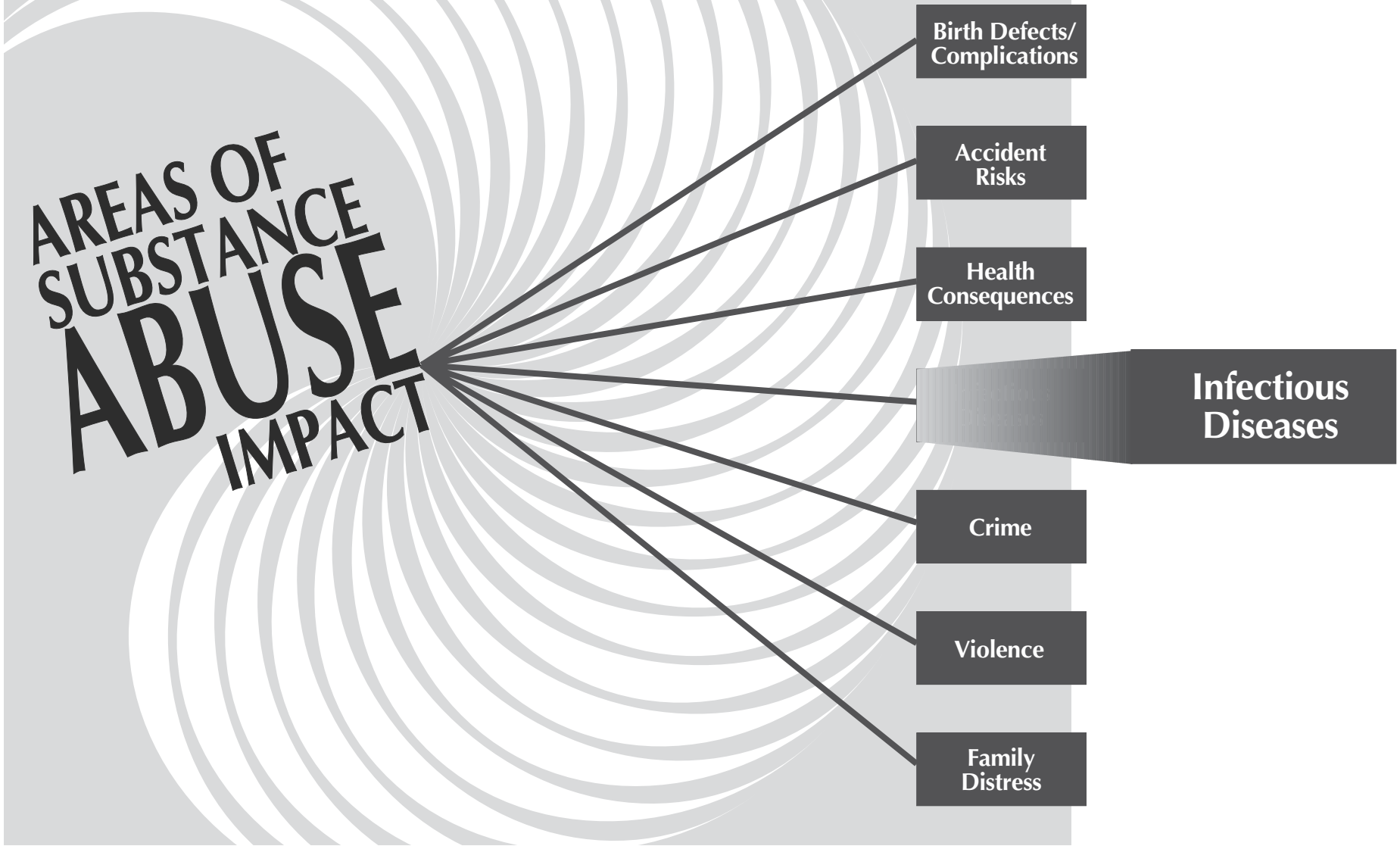



Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

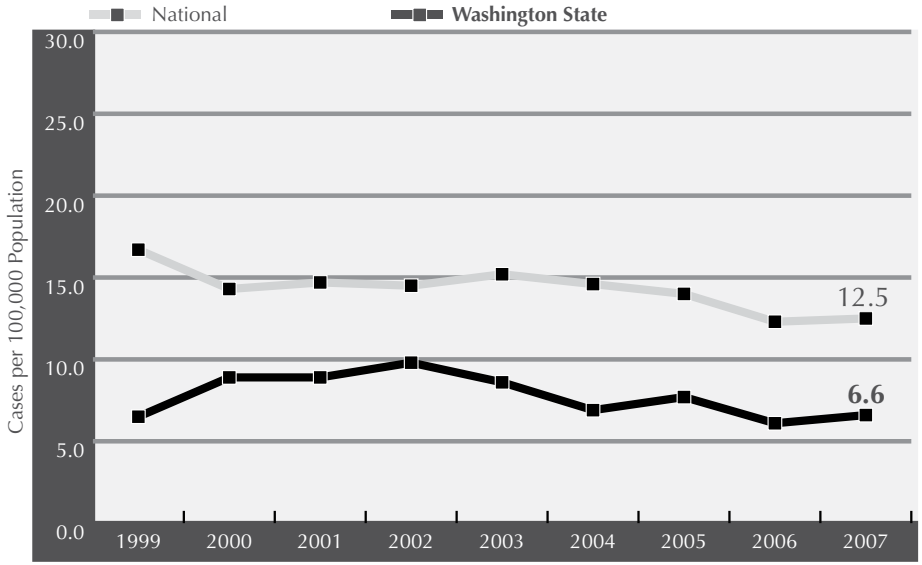
Heart disease is the leading cause of mortality in the United States, and ischemic heart disease (heart attacks) accounts for the largest portion of heart disease deaths. About 12 million Americans have ischemic heart disease. Prevention strategies include reducing blood cholesterol, high blood pressure, obesity and excessive weight gain, and cigarette smoking, as well as increasing amounts of physical activity.[1] Quitting smoking reduces risks of heart disease and heart attacks regardless of age of cessation.[2] There were 7,385 deaths from ischemic heart disease in Washington State in 2007.

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 12-6. Washington, DC: 2000.
[2] Taylor, D. et al. "Benefits of Smoking Cessation for Longevity." *American Journal of Public Health* 92(6), 2002.

# The Problem: Substance Abuse Prevalence & Trends



# The Reported AIDS Case Rate in Washington State is Significantly Lower than the Nation.*




Source: National and state data from the Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report 2007,* Vol. 19, 2009.

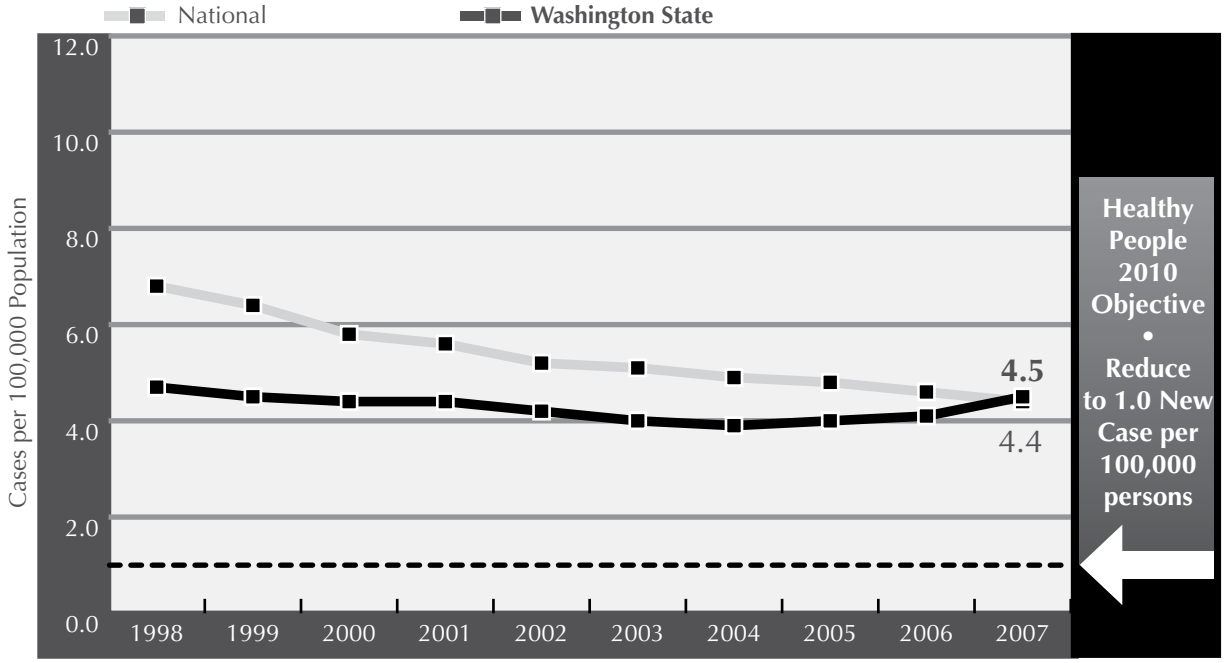
From 1982 through 2007, 12,142 AIDS (Acquired Immune Deficiency Syndrome) cases were reported in Washington State, and there were 5,505 deaths from the disease. As of December 2008, there were 5,799 Washington residents living with AIDS. Some 18% of AIDS cases in Washington State were traceable to possible exposure from injection drug use, substantially lower than the percentage of cases attributed to injection drug use nationally.[1] Studies have shown that cities that implemented needle exchange programs early in the AIDS epidemic - such as Seattle and Tacoma - have much lower infection rates among injection drug users (IDUs).

This graph indicates that the reported AIDS case rate in Washington is consistently lower and is now approximately half that of the nation. Since 1995, the AIDS case rate has generally been in decline, reflecting the effectiveness of new treatments in preventing HIV (human immunodeficiency virus) infection from progressing to AIDS. However, there is concern about an increase in behaviors that put individuals at risk for HIV transmission. Nationally, well over half of individuals diagnosed with AIDS live longer than 9 years after the diagnosis.[2]

** Case counts are provisional; reporting is considered incomplete for several years.*

[1] Office of HIV Prevention and Education, Washington State Department of Health, 2008.
[2] Centers for Disease Control and Prevention, *HIV/AIDS Surveillance Report 2005* Vol. 17, 2006.

# The Case Rate for New Tuberculosis Cases in Washington State Ticked Upward in 2007.




Source: National data from the Division of Tuberculosis Elimination, Center for HIV, STD, and TB Prevention, Centers for Disease Control and Prevention. State data from Washington State Department of Health, *Washington State Communicable Disease Report 2007*.

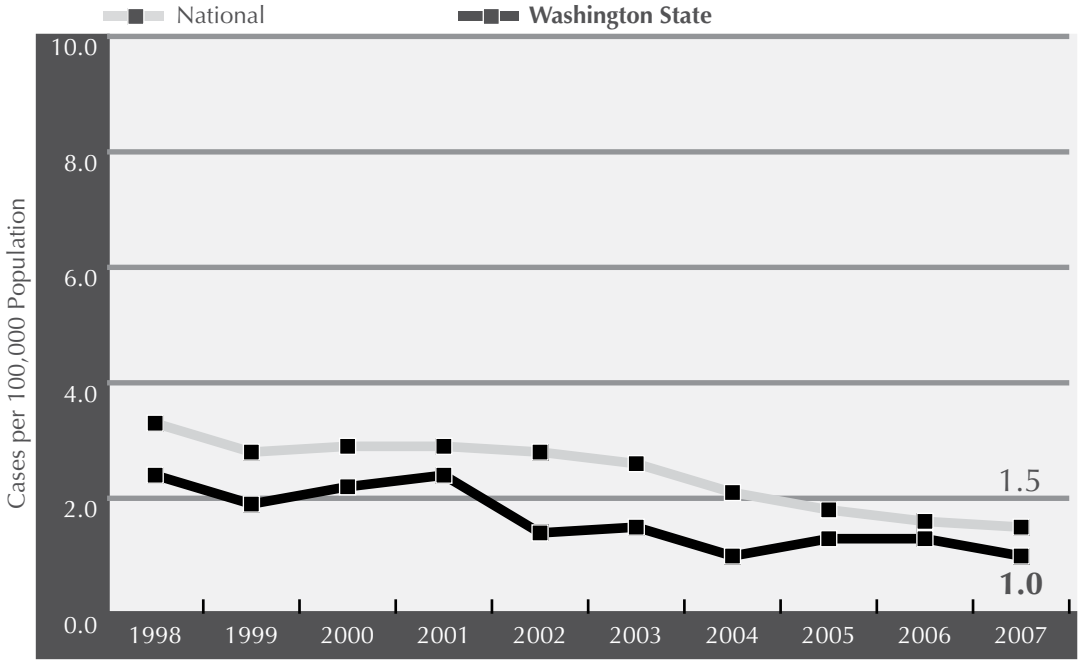
Multiple risk factors, including poverty, homelessness, substance abuse, gaps in health care infrastructure, and the human immunodeficiency virus (HIV) epidemic, are associated with new tuberculosis cases. Ensuring that patients with active tuberculosis infection complete curative therapy early is essential to curbing the disease's spread. Washington State has adopted treatment provider regulations to screen all chemical dependency patients to help prevent and control the spread of the disease.

This graph indicates that until 2007 Washington State had a consistently lower tuberculosis rate than the nation. There were 291 new tuberculosis cases in Washington State in 2007, 161 in King County, the highest number in 30 years, and where the case rate of 8.6/100,000 was almost twice the state case rate. Some 76% of the King County cases were to foreign-born individuals, and 12% were resistant to at least one tuberculosis medication.[1] There were 12 reported tuberculosis deaths in 2007.[2]



[1] Epidemiology, Prevention Division, Public Health - Seattle and King County *Epi-Log*, 48(3), March 2008.
[2] Communicable Disease Epidemiology Section. *Washington State Communicable Disease Report 2007*. Shoreline, WA: Washington State Department of Health, Epidemiology, Health Statistics and Public Health Laboratories, 2008.

# The Rate of Acute Hepatitis B in Washington State Has Declined By More than Half in the Past Decade.



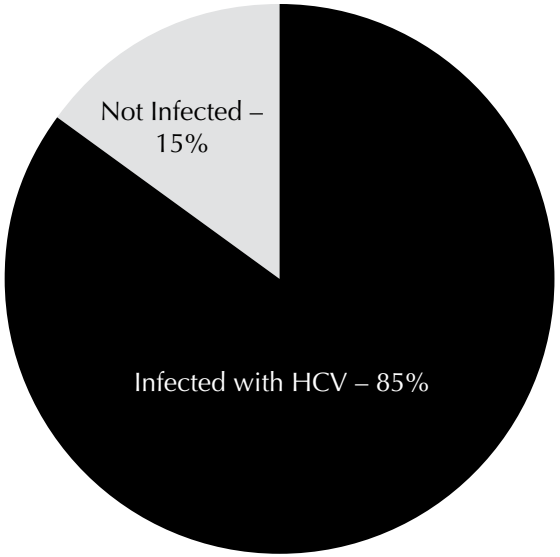

National data from the Epidemiology Program Office, National Notifiable Disease Surveillance System, Centers for Disease Control and Prevention. State data from Washington State Department of Health, *Washington State Communicable Disease Report 2007*.

Injection drug use is a major risk factor for hepatitis B infection. Most cases occur in young adult risk groups, including persons with a history of multiple sex partners, men who have sex with men, injection drug users, incarcerated persons, and household and sex contacts of infected partners. It may also be transmitted perinatally.[1]

This graph indicates that the rate of acute hepatitis B cases in Washington State has declined substantially over the past decade. Hepatitis B is a serious disease that attacks the liver, and chronic hepatitis B infection, which may be carried without sign of infection, is associated with cirrhosis, liver cancer, and liver failure. The greatest decline in infections over the past decade has been in children and adolescents, and associated with routine childhood vaccination.Nationally, the acute hepatitis B case rate in 2007 was the lowest ever recorded.[2] There were 65 reported acute hepatitis B cases in Washington State in 2007, with one death.[3]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 14-15. Washington, DC: 2000.
[2] Daniels, D., Grytdal, S., and Wesley, A. "Surveillance for Acute Viral Hepatitis – United States, 2007". *Morbidity and Mortality Weekly Report* 58(SS-3), May 22, 2009.
[3] Communicable Disease Epidemiology Section. *Washington State Communicable Disease Report 2007*. Shoreline, WA: Washington State Department of Health, Epidemiology, Health Statistics and Public Health Laboratories, 2008.

# Some 85% of Injection Drug Users in King County are Infected with Hepatitis C Virus (HCV).




Source: Community Epidemiology Work Group, National Institute on Drug Abuse, National Institutes of Health, *Recent Drug Trends in the Seattle-King County Area,* January 2006.

Of the 15,000-18,000 injection drug users (IDUs) in Seattle-King County, 85% are infected with the hepatitis C virus (HCV). Recent incidence studies indicate that 21% of non-infected Seattle-area IDUs acquire HCV each year.[1]

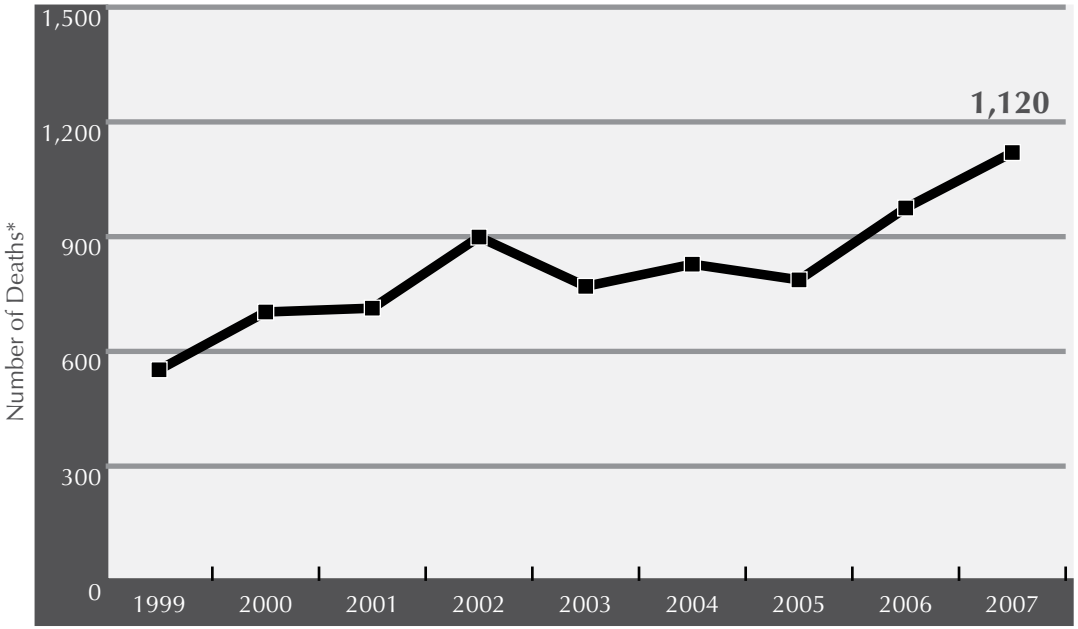
HCV is the most common chronic bloodborne viral infection in the United States. It is estimated that some 4.1 million, representing 1.6% of the population, have been infected with HCV, of whom 3.2 million are chronically infected. Most new infections are caused by injection drug use, though those who received blood clotting factors in the course of medical care before 1987 are at high risk. Infection can also be transmitted perinatally (risk = 4%) or through sexual contact. Some 70% of chronically infected persons develop chronic liver disease or liver cancer. HCV is the leading reason for liver transplantation.[2]

Some 51,255 cases of chronic HCV were reported to the Washington State Department of Health from December 2000 through September 2008. However, chronic infection is known to be seriously underreported. The number of deaths in which HCV is recorded in death certificates alone or in combination with other causes doubled between 1999 and 2007, when there were 1,120 such deaths. While treatment protocols are improving rapidly, there is no known cure, and no effective vaccine against infection.[3] Even moderate use of alcohol is known to exacerbate liver injury resulting from HCV.



[1] Banta-Green, C. et al. "Recent Trends in the Seattle-King County Area, January 2006," *Epidemiologic Trends in Drug Abuse*, 2006.
[2] Centers for Disease Control and Prevention. *Hepatitis C Fact Sheet*, May 25, 2005.
[3] Infectious Disease and Reproductive Health Unit. *Washington State Chronic Hepatitis and Chronic Hepatitis C Surveillance Report.* Olympia, WA: Washington State Department of Health, 2009.

# The Number of Washington State Deaths Related to Hepatitis C (HCV) Has Doubled Since 1999.




Source: Infectious Disease and Reproductive Health Unit, *Washington State Chronic Hepatitis and Chronic Hepatitis C Surveillance Report*. Olympia, WA: Washington State Department of Health, 2009.

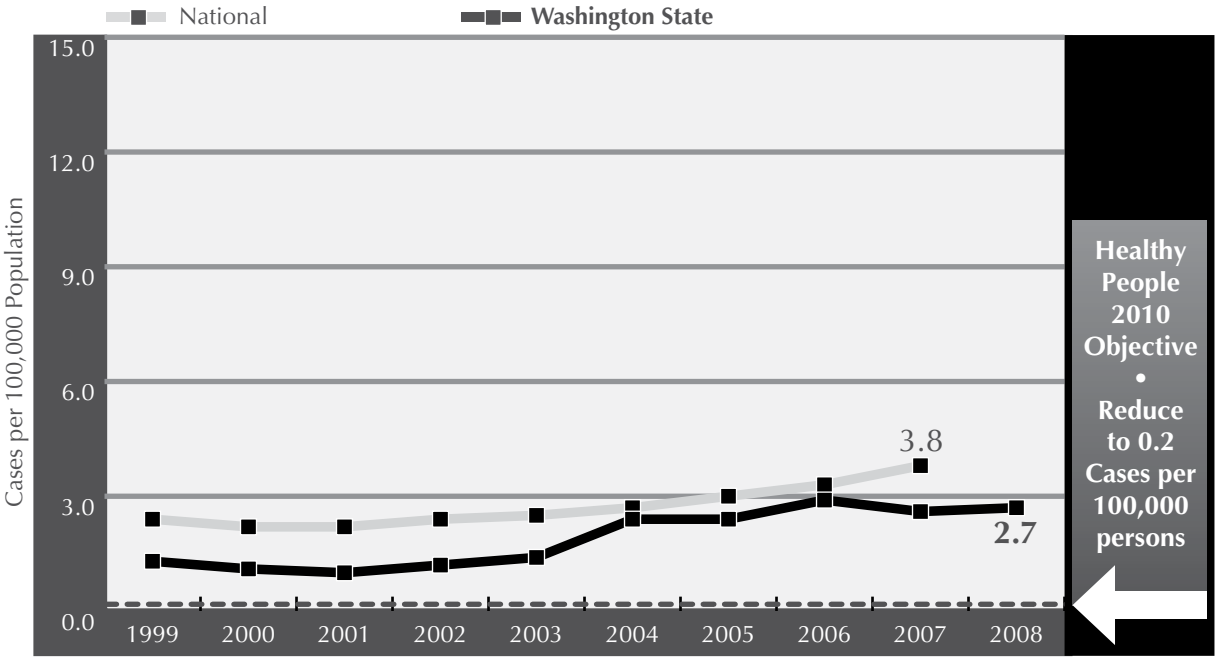
The number of reported deaths in Washington State related to HCV rose to 1,120 in 2007, more than double the number in 1999 (552), and almost eight times the number in 1992 (146). Of cases where the risk factor for exposure to HCV is known, injection drug use is by far the most common. The plurality of individuals with chronic HCV infection are ages 45-54, and predominately male. Of every 100 people infected with HCV infection, some 75-85 will develop chronic HCV infection. Of these, 60-70 will develop chronic liver disease; 5-20 will develop cirrhosis over a 20-30 period; and 1-5 will die from liver cancer. While there are available treatments, there is no known cure for HCV, and no vaccine to protect against the disease.[1]

**As recorded on death certificates with HCV as the underlying cause, or one of multiple causes.*



[1] Infectious Disease and Reproductive Health Unit. *Washington State Chronic Hepatitis and Chronic Hepatitis C Surveillance Report*. Olympia, WA: Washington State Department of Health, 2009.

# The Number of Primary and Secondary Syphilis Cases in Washington State is Now More than Double the Number in 2003.




Source: Change the state source to: State data from STD Services Section, Washington State Department of Health, *STI Fast Facts: Washington State 2008*.

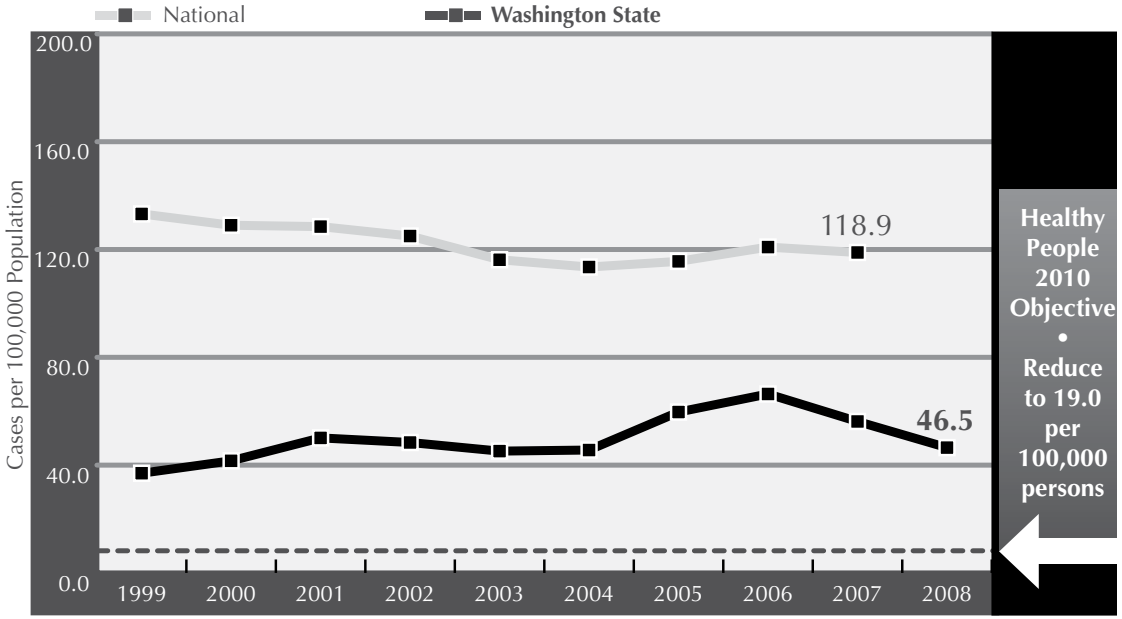
The spread of sexually transmitted diseases (STDs), including syphilis, is often linked to the use of alcohol and other drugs. The introduction of new illicit substance use into a community often can substantially alter sexual behavior in high-risk sexual networks. Increases in the exchange of sex for drugs, increases in the number of anonymous sex partners, decreases in motivation to use barrier protection, lowered ability to negotiate safe sex practices, and declines in attempts to seek medical treatment can all fuel epidemic spread of STDs.[1]

From a low of nine cases in 1996, Washington State has experienced a substantial increase in the number of primary and secondary (P&S) syphilis cases. There were 177 cases in 2008, more than double the 82 cases in 2003. King County, accounted for 71% of the newly reported 2008 cases.[2] Transmission is strongly associated with men having sex with men, and may be associated with substance abuse, notably methamphetamine and inhaled nitrites.[3] Counts of P&S syphilis cases may understate the problem, as cases are often diagnosed after they have gone beyond the primary and secondary stages and become latent.



[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 25-5. Washington, DC: 2000.
[2] STD Services Section. *STI Facts: Washington State 2008*. Olympia, WA: Washington State Department of Health, Community & Family Health, Infectious Disease & Reproductive Health, 2009.
[3] Public Health, Seattle & King County. *Screening Guidelines for Men Who Have Sex with Men (MSM)*. Seattle, WA: 2001.

# Gonorrhea Rates in Washington State Have Declined 47% since 2006, But are Well Higher than a Decade Ago.




Source: State data from STD Services Section, Washington State Department of Health, *STI Fast Facts: Washington State 2008*.

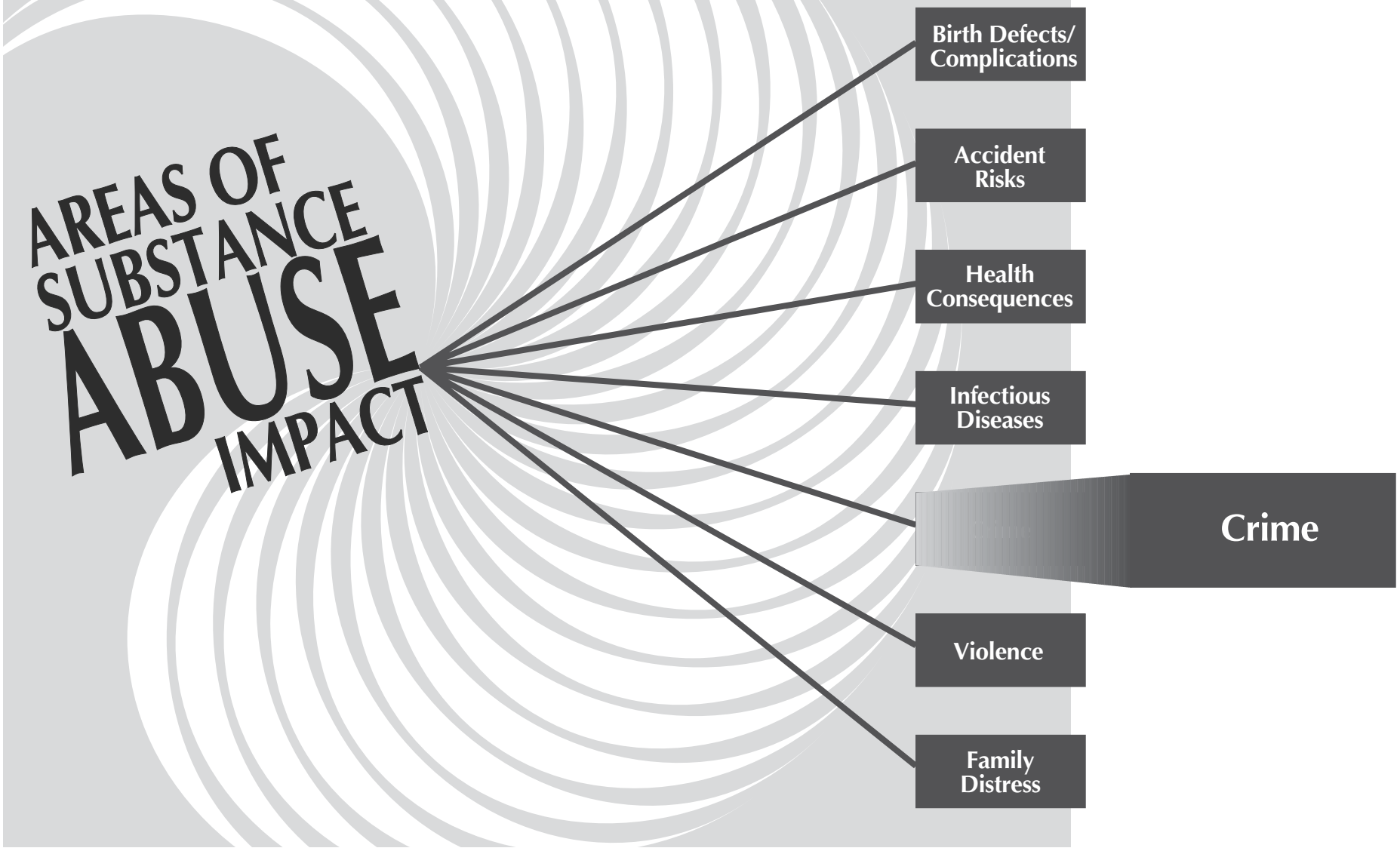
The spread of sexually transmitted diseases (STDs), including gonorrhea, is often associated with substance abuse. Increases in the exchange of sex for drugs, increases in the number of anonymous sex partners, decreases in motivation to use barrier protection, lowered ability to negotiate safe sex practices, and declines in attempts to seek medical treatment can all fuel epidemic spread of STDs. Sexually transmitted disease comprised 25% of all communicable disease in U.S. in 2008.[1]

Sexually transmitted infections comprised 75% of all communicable disease in Washington State in 2008. After experiencing a serious resurgence in gonorrhea cases in the past decade, reported gonorrhea cases have dropped substantially, from 4,211 cases in 2006 to 3,069 cases in 2008, representing a 46.5% decline. This decline may be due, in part, to more appropriate treatment options now being utilized. Highest incidence is among females in the 20-24-year age range (216 per 100,000).[2]

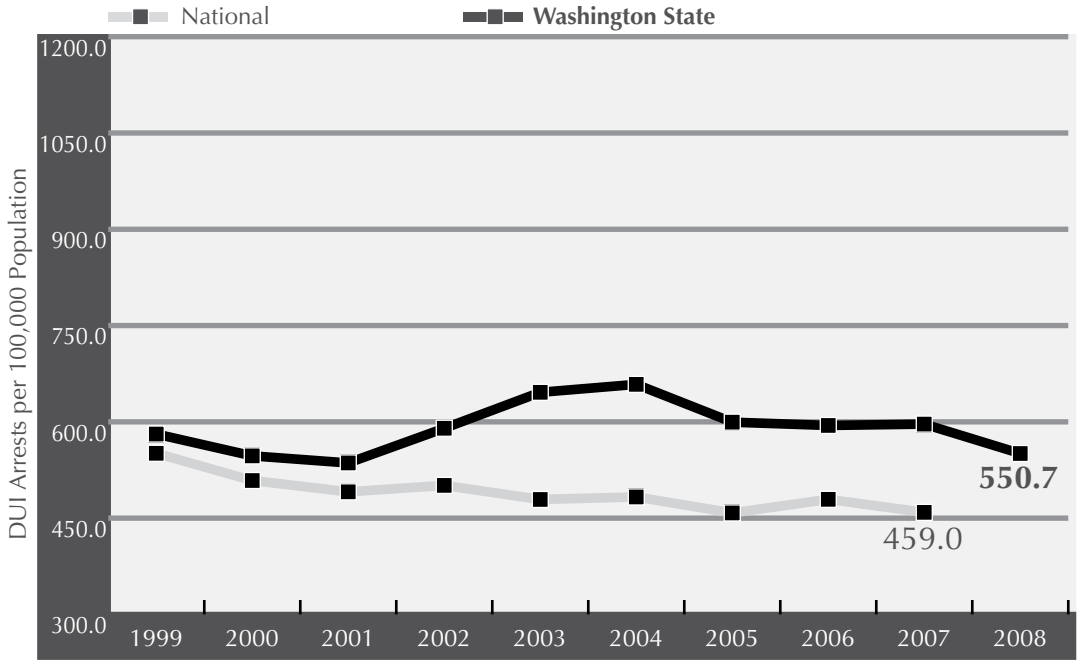
Gonorrhea infections are a major cause of pelvic inflammatory disease, tubal infertility, ectopic pregnancy, and chronic pelvic pain. Epidemiologic studies indicate that gonococcal infections such as gonorrhea may facilitate HIV transmission.

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 25-5. Washington, DC: 2000.
[2] STD Services Section. *STI Facts: Washington State 2008*. Olympia, WA: Washington State Department of Health, Community & Family Health, Infectious Disease & Reproductive Health, 2009.

# The Problem: Substance Abuse Prevalence & Trends



# Driving-Under-the-Influence Arrest Rates in Washington State Fell in 2008.

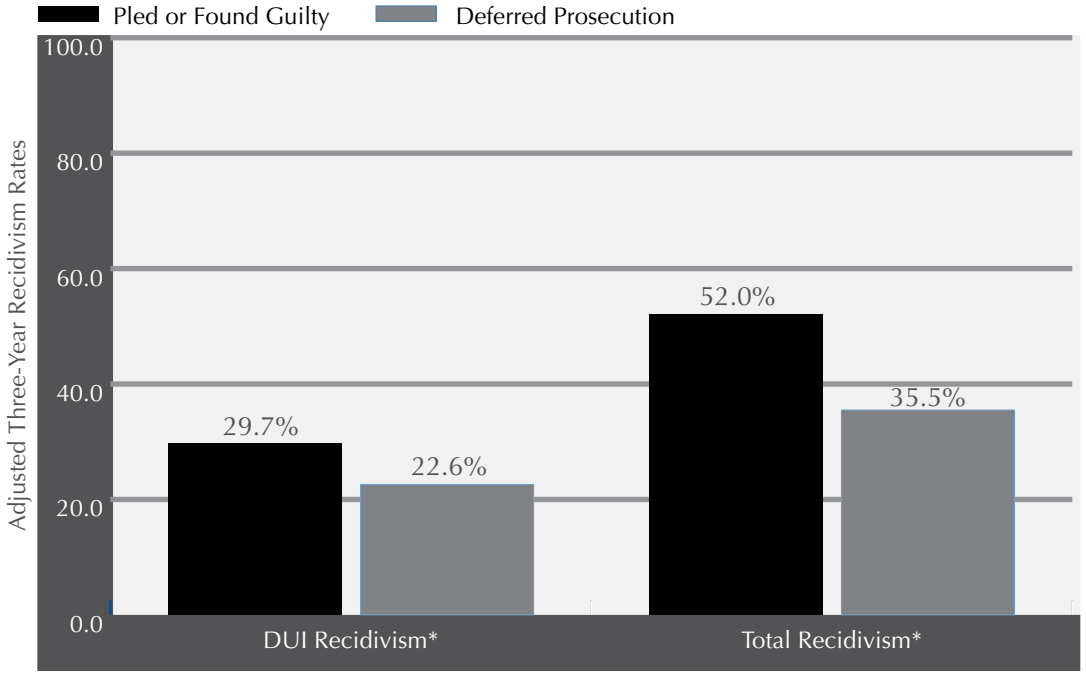



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* Annual Report. State data from the Washington Association of Sheriffs & Police Chiefs.

Data for alcohol-related motor vehicle arrests may reflect a jurisdiction's laws, enforcement policy, financial resources, and officer discretion, in addition to the actual number of alcohol-related driving incidents. Washington State enacted new alcohol-related motor vehicle statutes in 1998, including lowering the blood alcohol concentration (BAC) for proof of intoxication to .08, and zero tolerance for drivers under age 21. Driving-Under-the-Influence arrest rates in Washington State declined by 7.7% in 2008.

NEW/CHANGING TREND

# Deferred Prosecution, Including Two Years of Chemical Dependency Treatment, Results in Reduced DUI Recidivism.




Source: Washington State Institute for Public Policy, *Deferred Prosecution of DUI Cases in Washington State: Evaluating the Impact on Recidivism*. Olympia, WA: August 2007.

Deferred prosecution is a unique Washington State program in which chemically dependent driving-under-the-influence (DUI) offenders can petition to have their charges deferred if they meet certain conditions, including participation in a chemical dependency treatment program for two years. There were 5,520 deferred prosecutions in progress in 2008.[1]

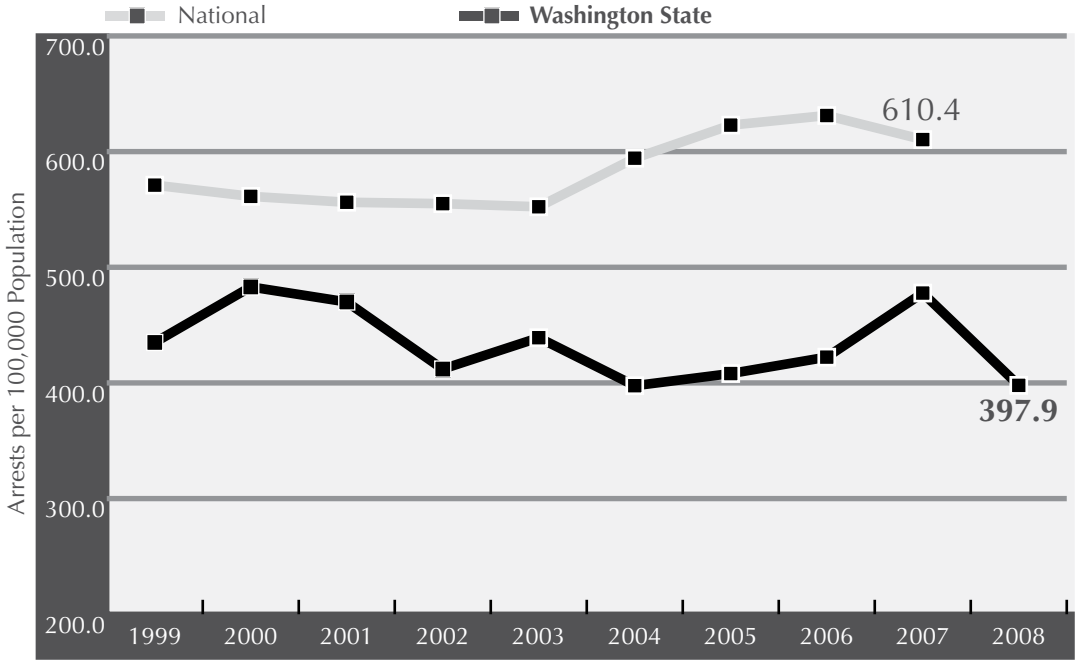
A 2007 study indicates that defendants who received a deferred prosecution were 23.9% less likely to be arrested for another DUI within three years of the first case when compared with those who pled or were found guilty, and 31.7% less likely to have a subsequent DUI, criminal traffic, or alcohol-related case filed.[2]

** Includes subsequent DUI, criminal traffic, or alcohol-related case file.*



[1] Administrative Office of the Courts. *DUI Disposition Table 1998-2008 – Caseloads of the Courts Reports*, Olympia, WA: April 2009.
[2] Washington State Institute for Public Policy. *Deferred Prosecution of DUI Cases in Washington State: Evaluating the Impact on Recidivism*. Olympia, WA: August 2007.

# The Rate of Drug-Related Arrests in Washington State is Lower than the Nation.

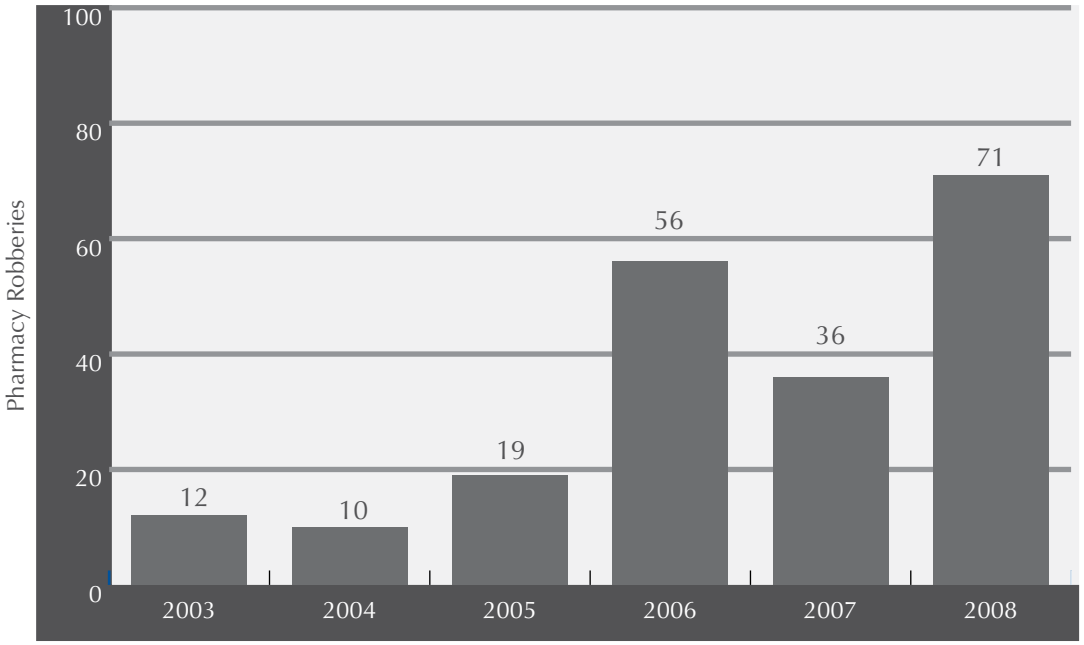



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* Annual Reports. State data from the Washington Association of Sheriffs & Police Chiefs.

Data for drug-related arrests may reflect a jurisdiction's laws, enforcement policy, financial resources, and officer discretion, in addition to the actual number of drug violations committed. There were 23,300 adult and 2,909 youth arrested for drug violations in 2008. Many individuals now receive judicially supervised treatment in lieu of incarceration with funds provided under the Criminal Justice Treatment Account. Drug-related arrests in Washington State declined by 16.7% in 2008.

NEW/CHANGING TREND

# Robberies of Washington State Pharmacies Have Increased Six-Fold Since 2003.




Source: Drug Enforcement Administration, 2009.

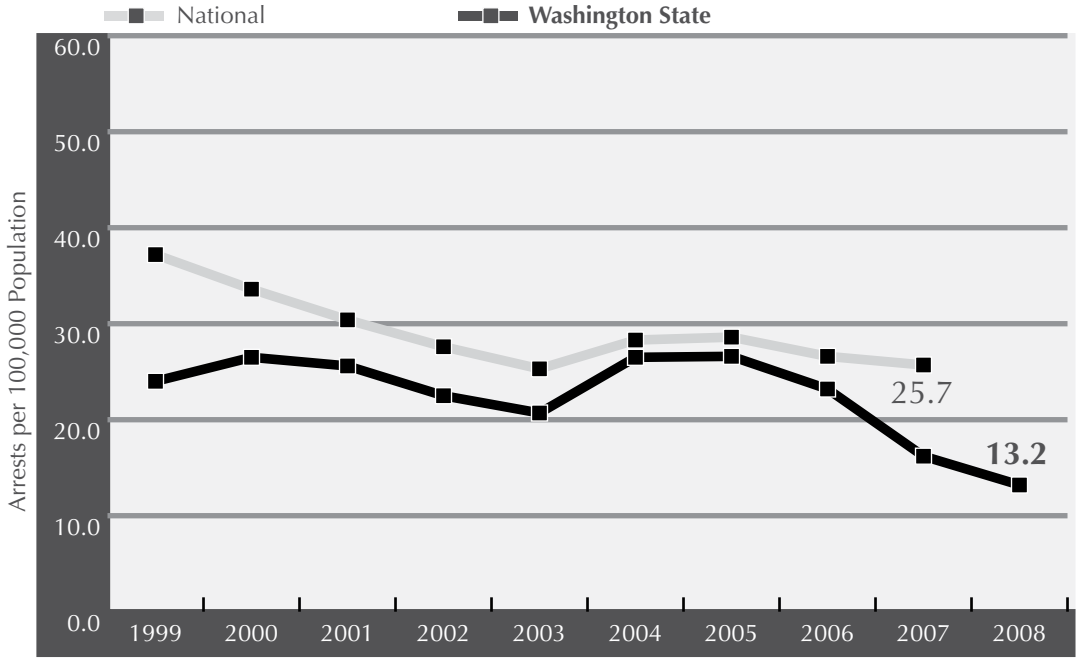
The number of pharmacy robberies in Washington State is rising rapidly. In the first six months of 2009, there were 54 additional robberies. Most are for prescription-type opiates, especially OxyContin.[1]

From January to May 2009, Washington Walgreens' 113 pharmacies experienced 45 robberies. In contrast, during the same period, the 548 Walgreens pharmacies in Illinois experienced just one, and the 628 in Texas experienced nine. Nationwide, the average Walgreens pharmacy dispenses ten OxyContin prescriptions per store per month; in Washington State, the average is 15. In 82% of robberies of Walgreens pharmacies in Washington State, OxyContin is asked for by name. It is believed that many of the robberies are committed by repeat offenders.[2]



[1] Drug Enforcement Administration, 2009.
[2] Walgreens Co. Presentation to the Assistant U.S. Attorneys/Drug Enforcement Administration Meeting, Seattle, Washington, June 9, 2009.

# Arrest Rates in Washington State for Prostitution are Below the National Rate.




Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State* annual reports.

The Arrestee Drug Abuse Monitoring Program reported that 78.3% of those arrested for prostitution in Seattle in 1999 tested positive for illegal drugs, mostly for cocaine.[1] Prostitution is associated with the spread of HIV/AIDS and other sexually transmitted diseases.

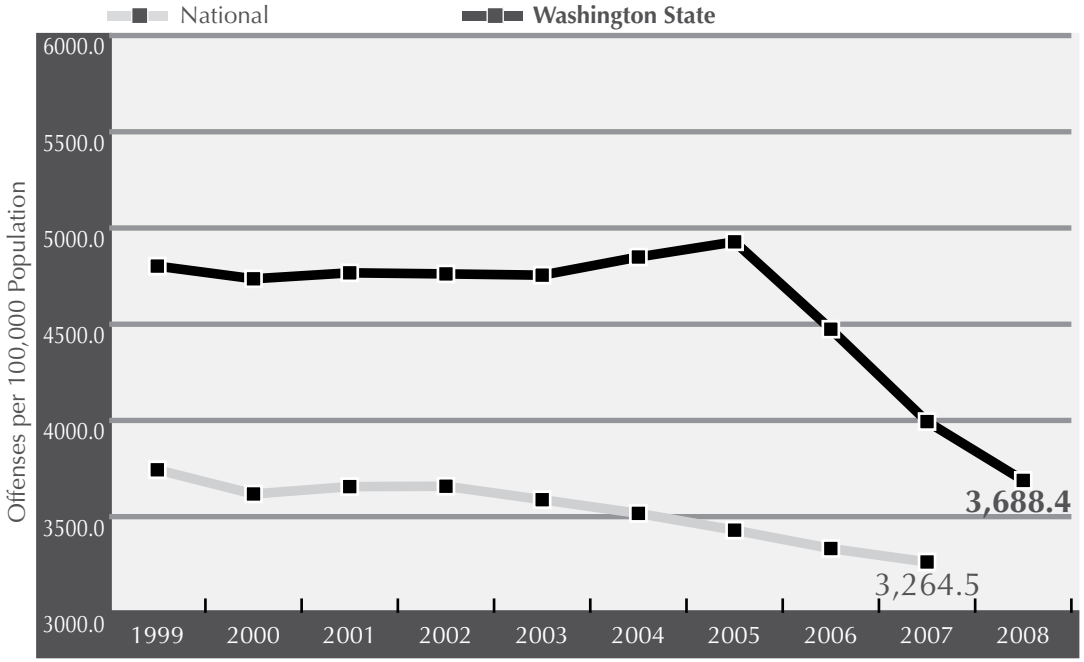
This graph indicates that arrest rates for prostitution in Washington State are lower than that of the nation. Of the 872 prostitution arrests in Washington State in 2008, 227 (representing 26.0% of the total) were male. Some 62 arrests were of youth under age 18. It should be noted that arrest rates may be influenced by a jurisdiction's financial resources, enforcement policy, and officer discretion, as well as the actual level of criminal activity.



[1] Office of Justice Programs, National Institute of Justice. *Arrestee Drug Abuse Monitoring Program 1999 Annual Report.* Washington, DC: U.S. Department of Justice, 2000.

NEW/CHANGING TREND

# Washington State Has a Higher Property Crime Arrest Rate than the Nation, But It has Been Declining Rapidly.




Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington* annual reports.

The Arrestee Drug Abuse Monitoring Program found that in 2000, 73.4% of males arrested for property offenses in King County, and 71.5% arrested for property offenses in Spokane County tested positive for illegal drugs.[1]

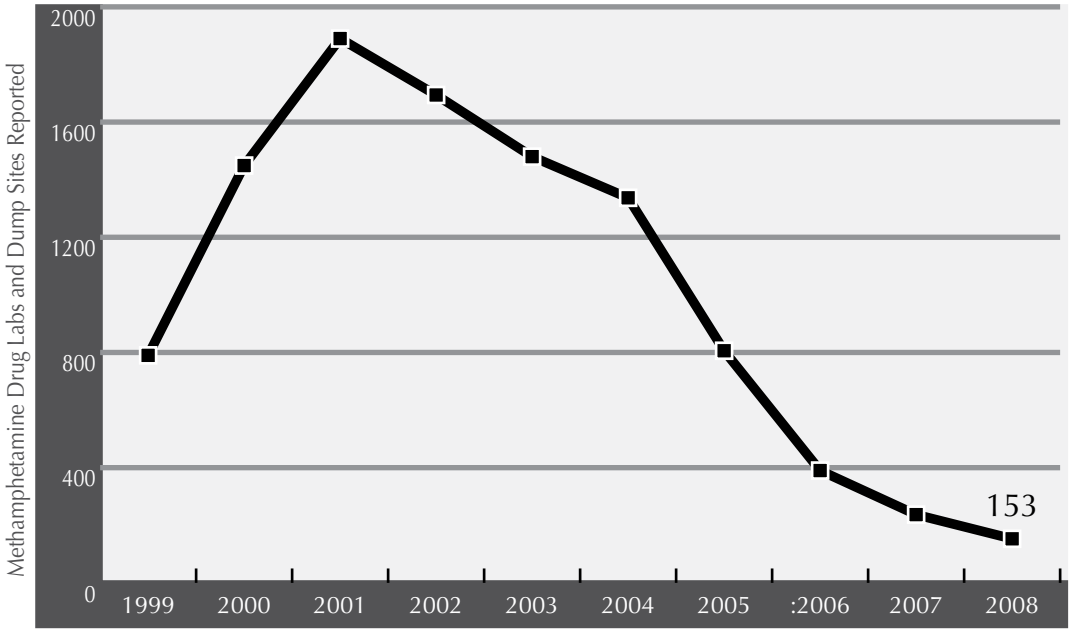
This graph indicates that the Washington State arrest rate for property crimes are higher than the nation, but it has been declining rapidly. The property crime index includes burglary, larceny-theft, motor vehicle theft, and arson offenses.



[1] Office of Justice Programs, National Institute of Justice. *Arrestee Drug Abuse Monitoring Program 2000 Annualized Site Reports* (Prerelease), 139-146. Washington, DC: U.S. Department of Justice, 2001.

# The Number of Reported Methamphetamine Laboratories and Dump Sites in Washington State is at Its Lowest Point in More Than a Decade.

***Number of Reported Meth Labs and Dump Sites***



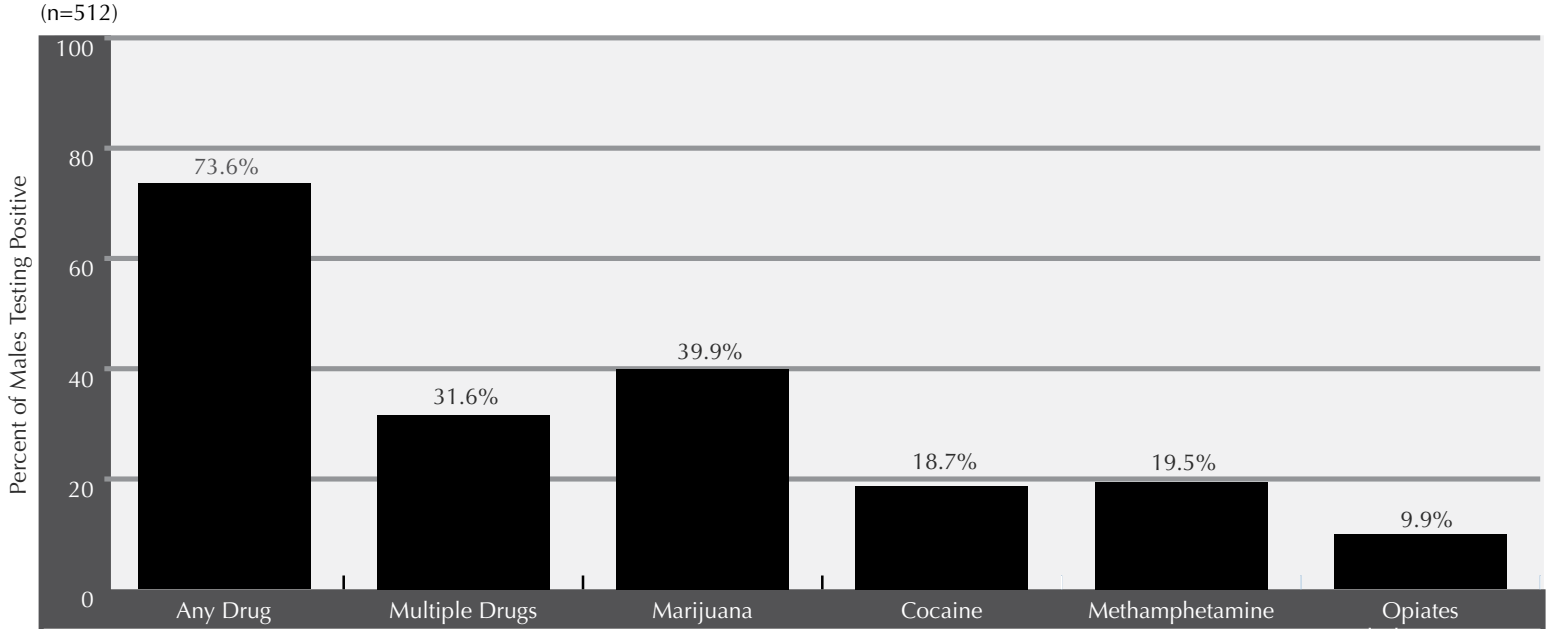

Source: Washington State Department of Ecology, 2009.

This graphic indicates that after dramatic increases early in the decade, the number of illegal methamphetamine (meth) laboratories and dump sites in Washington State continues to drop, and has fallen 91.9% since 2001. The largest number of reports in 2008 came from Pierce (62), King (29), and Snohomish (12) Counties.

It is possible, but not yet substantiated, that the number of meth lab reports reflects a decline in the level of illicit use of the drug in communities. It is also suggested by law enforcement agencies, however, that drug dealers are now importing finished product from elsewhere, rather than manufacturing it, and that there is now a smaller number of large labs, accounting for most of the documented decline. Strong legislative efforts have also likely stemmed the availability of precursor chemicals. The Northwest High Intensity Drug Trafficking Area (NW HIDTA) Threat Assessment no longer considers methamphetamine the greatest illicit drug threat to Washington State, it having been replaced with powder cocaine.[1]

[1] Northwest High Intensity Drug Trafficking Area. *Threat Assessment and Strategy for Program Year 2010*. Seattle, WA: 2009.

# Almost Three-Quarters of Male Arrestees Booked Into the Snohomish County Jail Between November 2002 – February 2003 Tested Positive for Drugs.




Source: Gilson, M., and Kabel, J., *The Snohomish County Arrestee Substance Abuse (SCASA) Study*. Olympia, WA: Looking Glass Analytics, 2003.

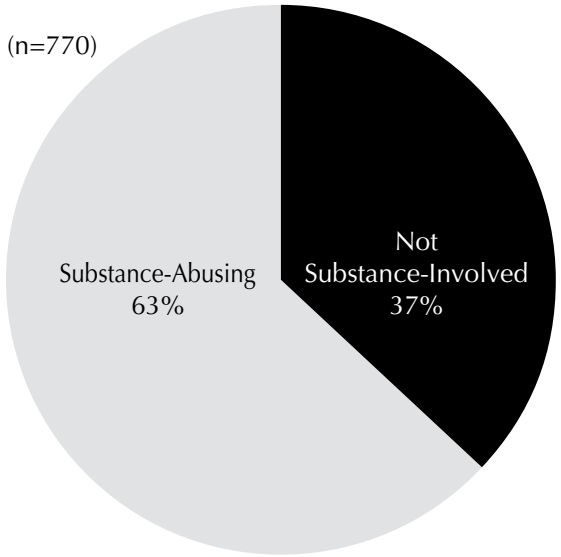
Modeled on an approach pioneered by the defunded federal Arrestee Drug Abuse Monitoring Program, males arrested and booked into the Snohomish County Jail between November 2002 – February 2003 were tested for drug use via urine sampling, and interviewed. Almost three-quarters (73.6%) tested positive for illicit drugs. Some 39.9% of arrestees were classified as drug-dependent, with 23.7% classified as dependent upon alcohol. Arrestees that reported heavy substance use were more likely to have been arrested in the past 12 months, reported a greater number of lifetime arrests, and reported spending more time in jail than those who did not report heavy substance use.

Only 29% of Snohomish County arrestees reported receiving any treatment for chemical dependency during the previous year.[1]



[1] Gilson, M., and Kabel, J. *The Snohomish County Arrestee Substance Abuse (SCASA) Study: Characteristics of Drug Use Among Arrestees Booked Into Snohomish County Corrections Including Comparisons to Booked Arrestees in King and Spokane Counties*. Olympia, WA: Looking Glass Analytics, 2003.

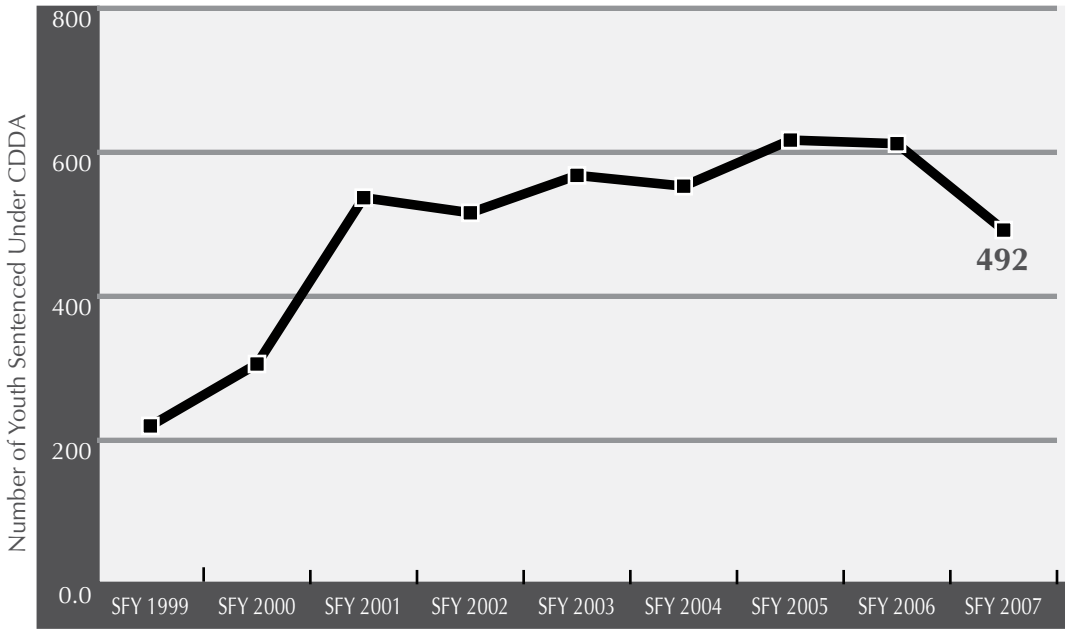
# Almost Two-Thirds of Youth Entering Juvenile Rehabilitation Administration Facilities in SFY 2007 Had Substance Abuse-Related Problems.




Source: Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services, June 2008.

More than half of youths admitted to Juvenile Rehabilitation Administration (JRA) institutions had substance abuse-related problems. JRA offers a continuum of chemical dependency treatment services within its facilities. All services are certified by the Division of Alcohol and Substance Abuse. In SFY 2007, 390 youth discharged from JRA facilities had received inpatient, intensive outpatient, or outpatient treatment.

# In State Fiscal Year 2007, 492 Youths Who Committed Offenses were Admitted to Treatment Under the Chemical Dependency Disposition Alternative.



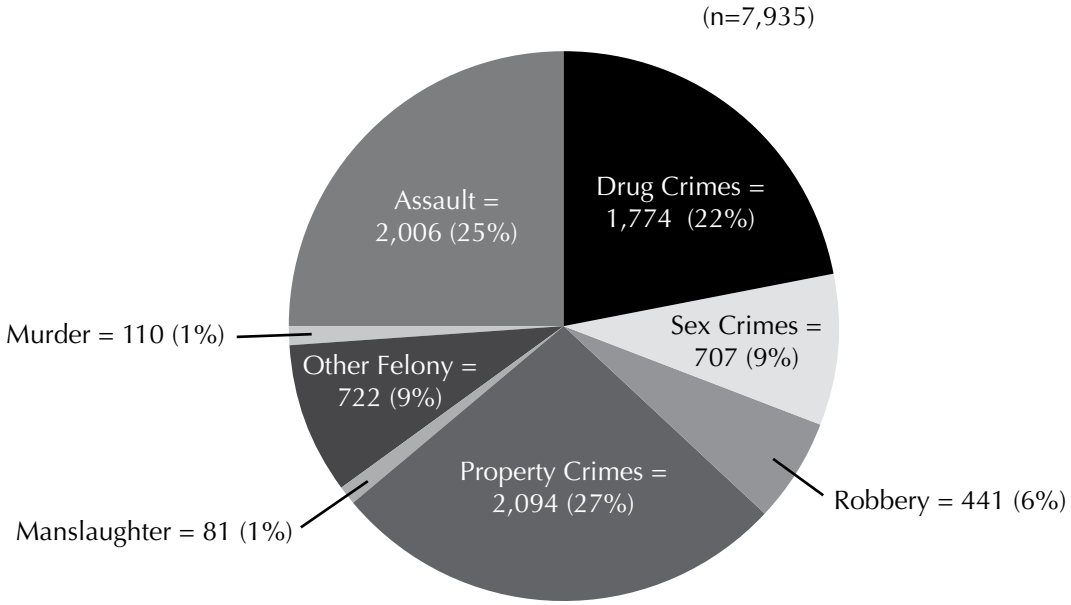

Source: Client Tracking System, Juvenile Rehabilitation Administration, Washington State Department of Social and Health Services, June 2008.

In 1998, the Legislature created the Chemical Dependency Disposition Alternative (CDDA). Under CDDA, juvenile courts may sentence chemically abusing and dependent youth to treatment rather than confinement. CDDA represents a collaboration among the Juvenile Rehabilitation Administration, Division of Alcohol and Substance Abuse, Medical Assistance Administration, local juvenile courts, University of Washington, and county alcohol/drug coordinators. A 2004 report to the Legislature prepared by the Alcohol and Drug Abuse Institute, University of Washington, found that committable youth completing CDDA incurred fewer convictions; were less likely to be detained; were more likely to be enrolled in school; were more likely to be working full-time; reported better family and social relationships; and reported fewer emotional difficulties.[1]



[1] Rutherford, M., et al. *Report to the Legislature: Chemical Dependency Disposition Alternative.* Olympia, WA: Washington State Department of Social and Health Services, Juvenile Rehabilitation Administration, 2004.

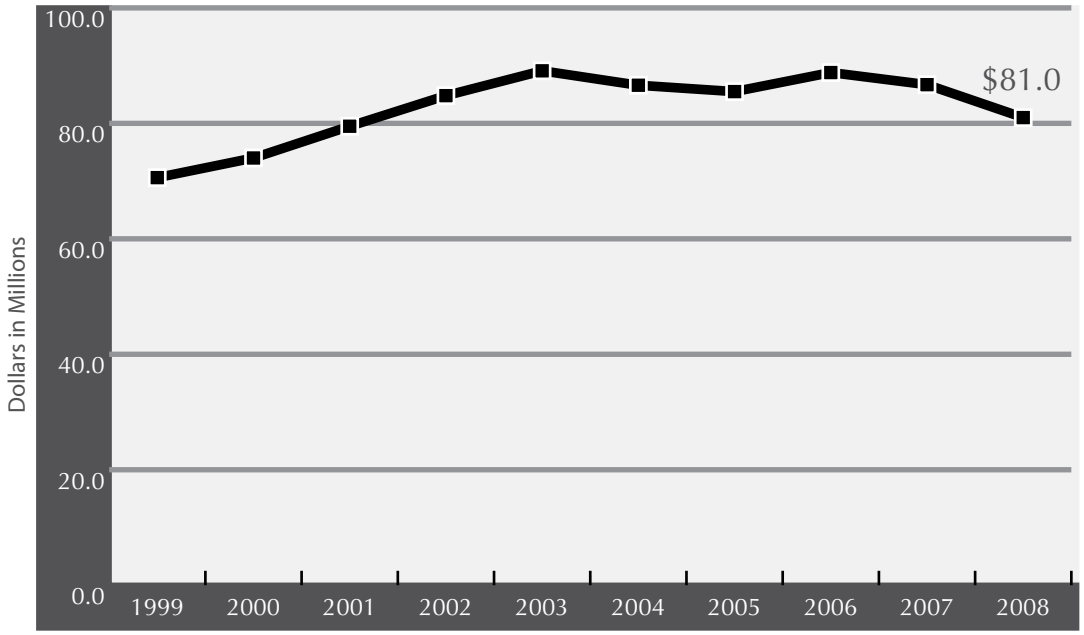
# In SFY 2008, 22% of the Convictions for Which Individuals were Sentenced to Department of Corrections Custody were for Drug Crimes.




Source: Washington State Department of Corrections, August 2009.

Drug crimes account for more than a quarter of the convictions for which individuals are sentenced to Department of Corrections custody. In addition, a substantial number of other crimes committed were drug-related, or were committed under the influence of alcohol or drugs. Approximately one-half of individuals admitted to total confinement are in need of chemical dependency treatment.

# The Costs* of Imprisoning Drug Offenders in Washington State Have Leveled Off.

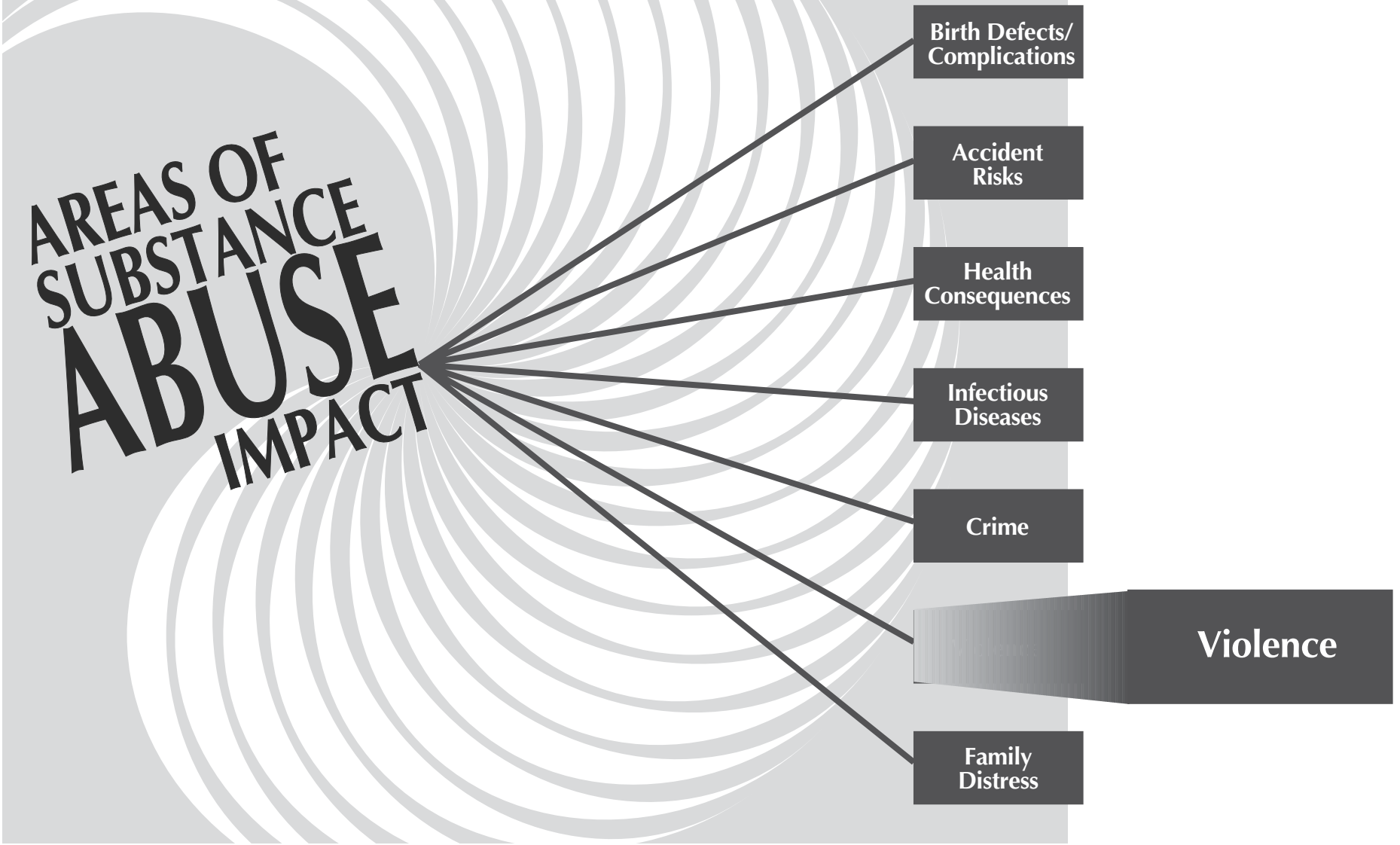



Source: Washington State Department of Corrections, August 2009.

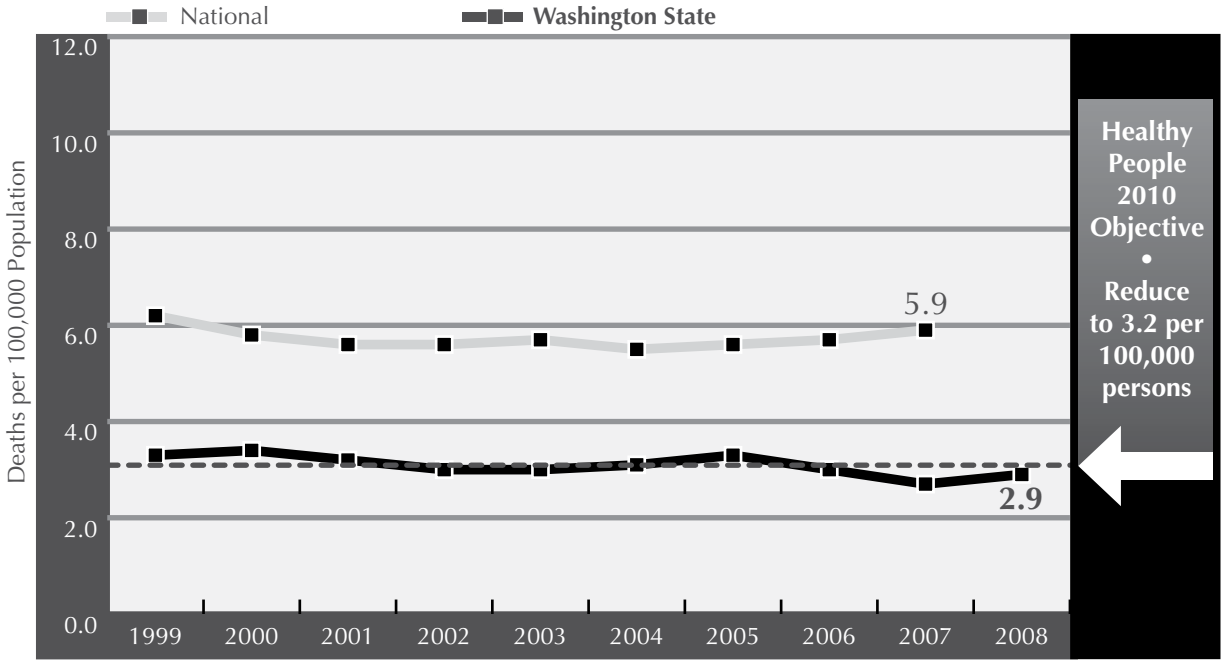
Costs* for imprisoning felony drug offenders in Washington State have grown faster than those for imprisoning other types of offenders. However, sentencing initiatives are now diverting a larger portion of drug offenders into chemical dependency treatment, and more treatment is now available through the Department of Corrections.

**Operating expenses only; excludes capital and supervision costs.*

# The Problem: Substance Abuse Prevalence & Trends



# The Homicide Rate in Washington State is Significantly Below the National Rate.



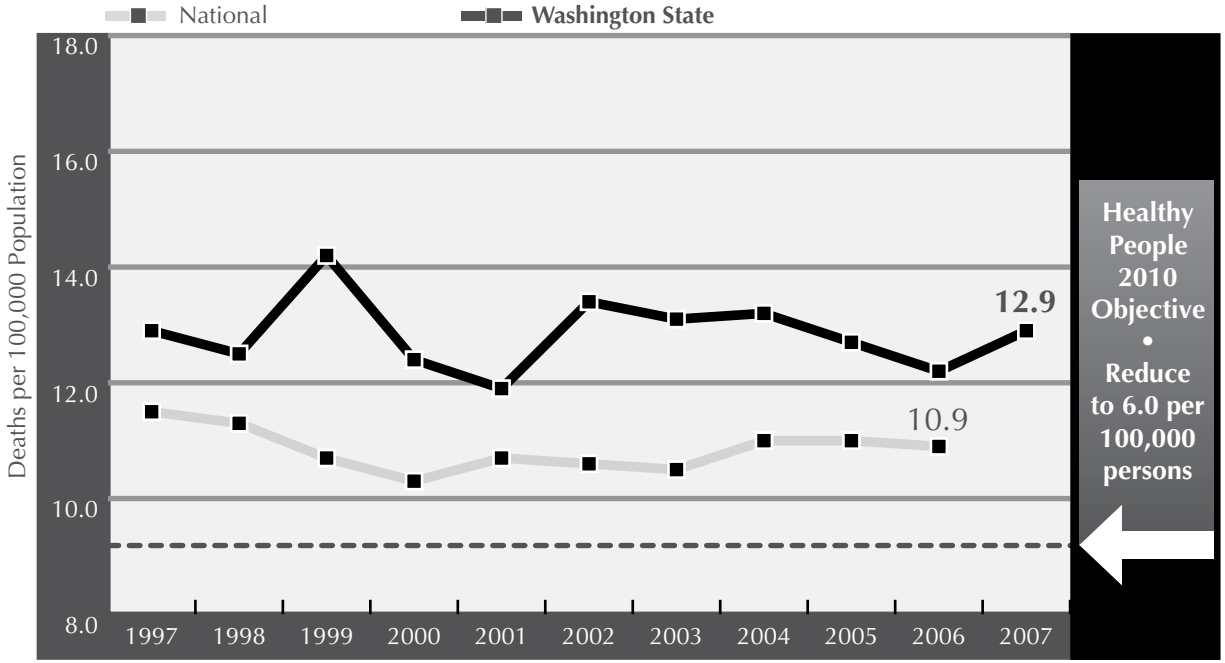

Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from the Washington Association of Sheriffs and Police Chiefs, *Crime in Washington State* annual reports.

There were 192 homicides reported in Washington State in 2008. Of these, seven were drug-related, and nine occurred as a result of brawls while under the influence of alcohol. It is unknown how many of the 168 homicides listed as "other than felony", including the 76 that may be related to child abuse and domestic violence, were associated with alcohol and other drug use.[1]

This graph indicates that Washington State's homicide rate has been lower than the national rate for more than a decade, and is below the *Healthy People 2010* objective.

[1] Washington Association of Sheriffs & Police Chiefs. *Crime in Washington State 2008 Annual Report.* Olympia, WA: 2009.

# The Suicide Rate in Washington State is Consistently Higher than the Nation.




Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

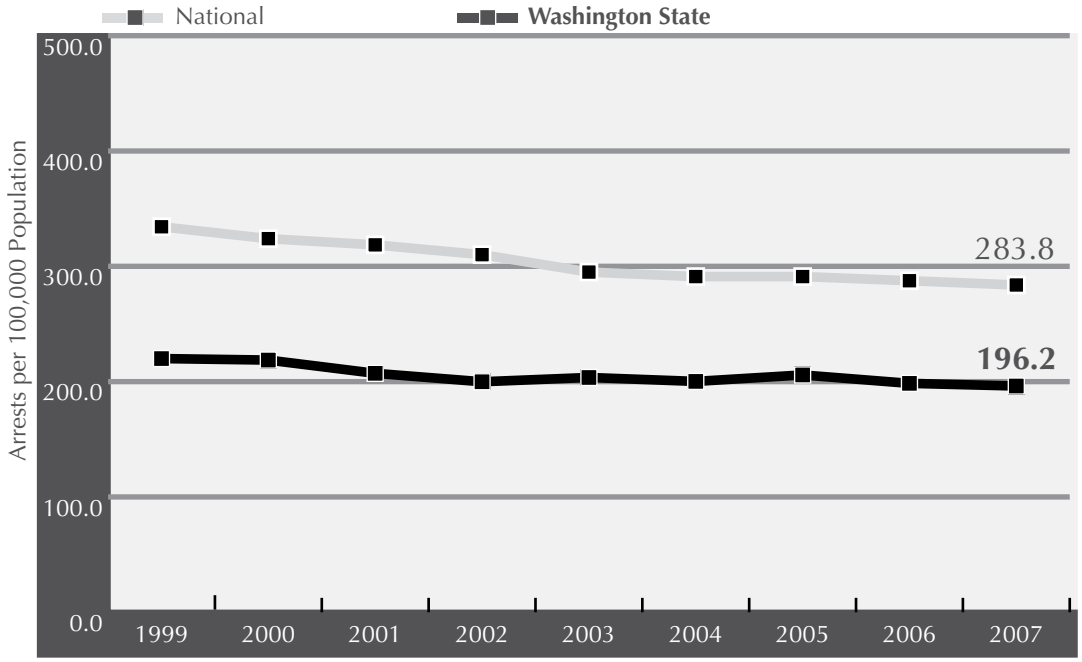
Alcohol and drug abuse are closely associated with the risk of suicide. A 1997 study found that use of alcohol almost doubles the risk of suicide in the home, while use of illegal drugs is associated with a seven-fold increase in risk.[1] However, the actual role of alcohol and other drugs in suicide is not clear. Some researchers see alcohol/drug involvement as self-medication to relieve depression or other psychological problems that eventually lead to suicide.[2] Others suggest that they loosen inhibitions or impair psychological and cognitive processes that normally constrain people from suicide.[3] Another perspective is that alcohol/drug use is part of the social disintegration that accompanies suicide.[4]

Washington State has a consistently higher suicide rate than the nation. There were 857 suicides in Washington in 2007. Suicide remains the second leading cause of death among young people ages 15-24 in Washington. Some 70% of youth who attempt suicide are frequent users of alcohol and/or other drugs.[5]



[1] Rivara, F. et al. "Alcohol and Illicit Drug Abuse and the Risk of Violent Death in the Home." *Journal of the American Medical Association* 278(7), 1997.
[2] Shaffer, D. "Suicide: Risk Factors and the Public Health." *American Journal of Public Health* 83, 1993.
[3] Zeichner, A. et al. "Alcohol and Aggression: Effects of Personal Threat on Human Aggression and Affective Arousal." *Alcoholism: Clinical and Experimental Research* 18, 1994.
[4] Yang, B. "The Economy and Suicide." *American Journal of Economics and Sociology* 51, 1992.
[5] Sher, L and Zalsman, G. "Alcohol and Adolescent Suicide." *International Journal of Adolescent Medicine and Health*. 17(3), 2005.

# The Rate of Aggravated Assaults in Washington State Remains Well Below the National Rate.

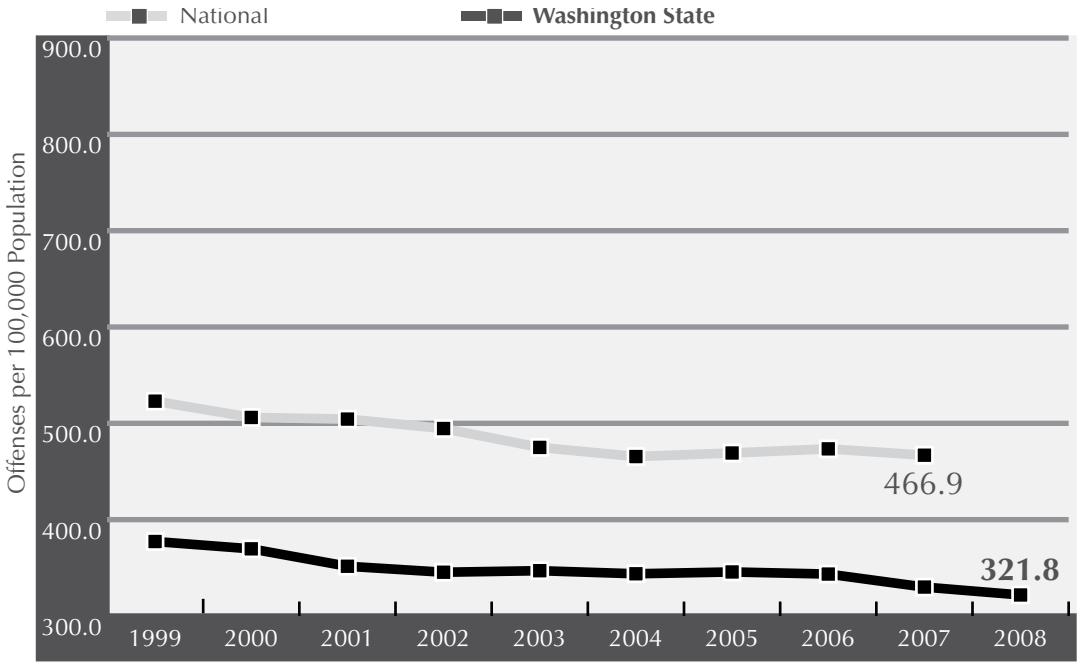



Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State* annual reports.

The federal Uniform Crime Reporting Program defines an aggravated assault as the unlawful attack by one person on another for the purpose of inflicting or aggravating bodily injury. An assault of this type is usually accompanied by the use of a weapon, or by means likely to produce death or severe harm.

This graph indicates that Washington State has a consistently lower rate of aggravated assaults than the nation.

# Washington State Consistently Has a Lower Rate of Violent Crime than the Nation.




Source: National data from the Federal Bureau of Investigation, U.S. Department of Justice, *Crime in the United States* annual reports. State data from Washington Association of Sheriffs & Police Chiefs, *Crime in Washington State* annual reports.

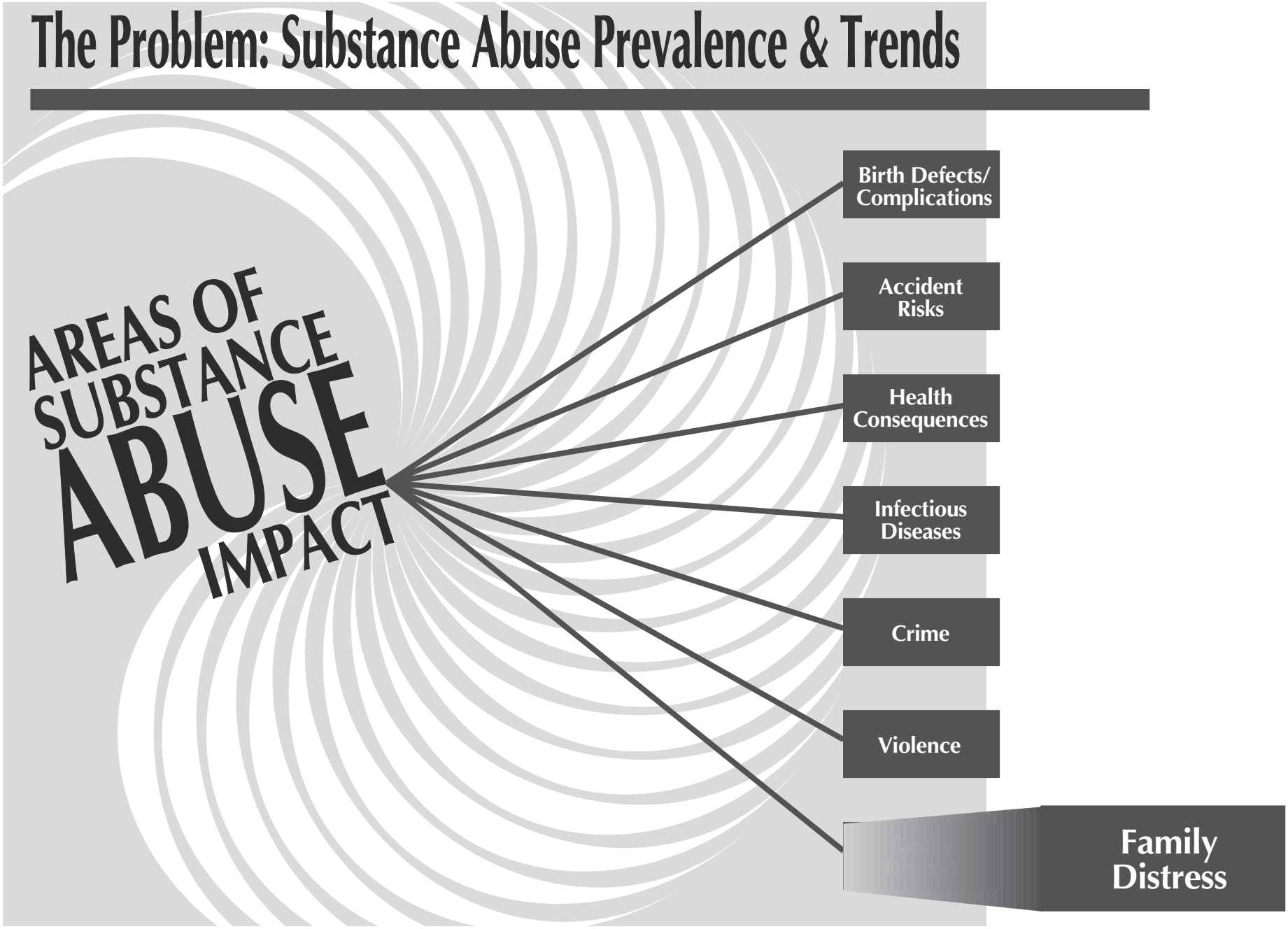
This graph indicates that Washington State has had a consistently lower incidence of violent crime than the nation for more than a decade. Violent crime rates are falling, both in the state and the nation. The Arrestee Drug Abuse Monitoring Program found that in 2004, 67.3% of adult males arrested for violent crimes in Seattle and 69.5% of adult males arrested for violent offenses in Spokane tested positive for illegal drugs.[1]

The most serious felony crimes against persons comprise the violent crime index. These offenses include murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault. All violent crimes involve force or the threat of force. This index is based upon offenses that become known to police, regardless of whether or not an arrest occurs.

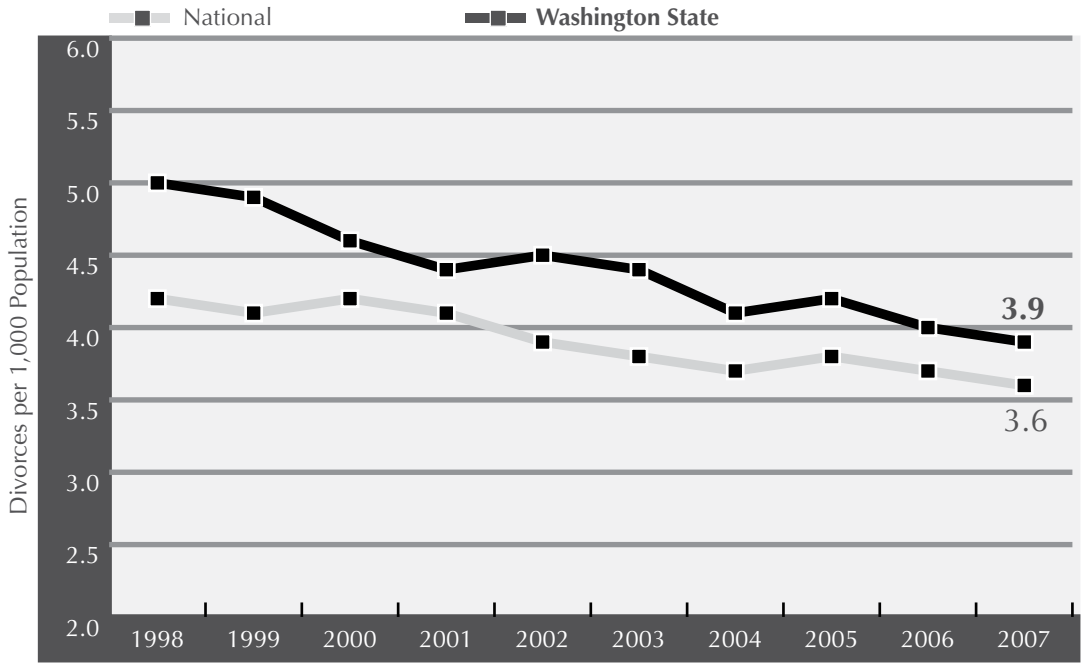


[1] Arrestee Drug Abuse Monitoring Program, Office of Justice Programs, National Institute of Justice. *Drug Use and Related Matters Among Adult Arrestees,2003.* Washington, DC: U.S. Department of Justice. 2004.

# The Problem: Substance Abuse Prevalence & Trends



# The Divorce Rate in Washington State Has Declined Over the Past Decade.



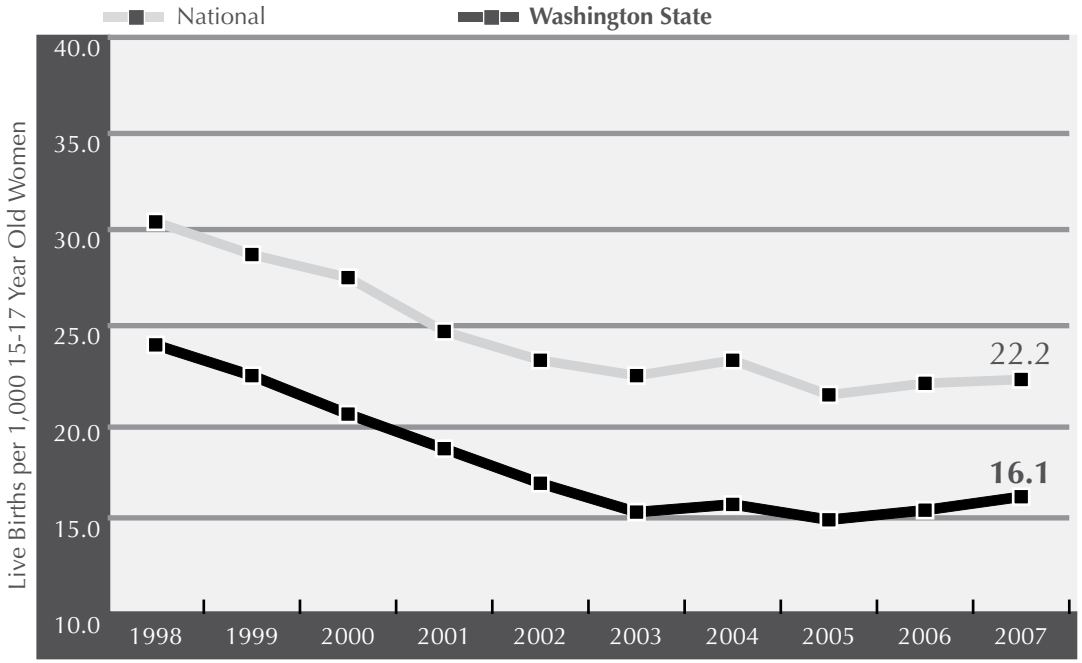

Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

Studies indicate that children from homes broken by marital discord are at a higher risk of drug use.[1]

This graph indicates that couples in Washington State experience more divorces (including annulments) than couples nationally. In 2007, at least 52.1% of the 25,270 divorces in Washington State involved families with children.[2] Nationally and in Washington State, the divorce rate is at its lowest point in more than three decades. Caution must be exercised in interpreting divorce rates, as they are computed based on the total population, rather than upon the number of individuals actually married.

[1] Kabel, J. et al. *Profile on Risk and Protection for Substance Abuse Planning in Washington State.* Olympia, WA: Department of Social and Health Services, Division of Alcohol and Substance Abuse and Research and Data Analysis, 1997.
[2] Washington State Department of Health, Center for Health Statistics, 2007.

# In 2007, the Birth Rate Among Teens Ages 15-17 in Washington State Rose Significantly.




Source: National data from the National Vital Statistics System, National Center for Health Statistics, Centers for Disease Control and Prevention. State data from the Center for Health Statistics, Washington State Department of Health.

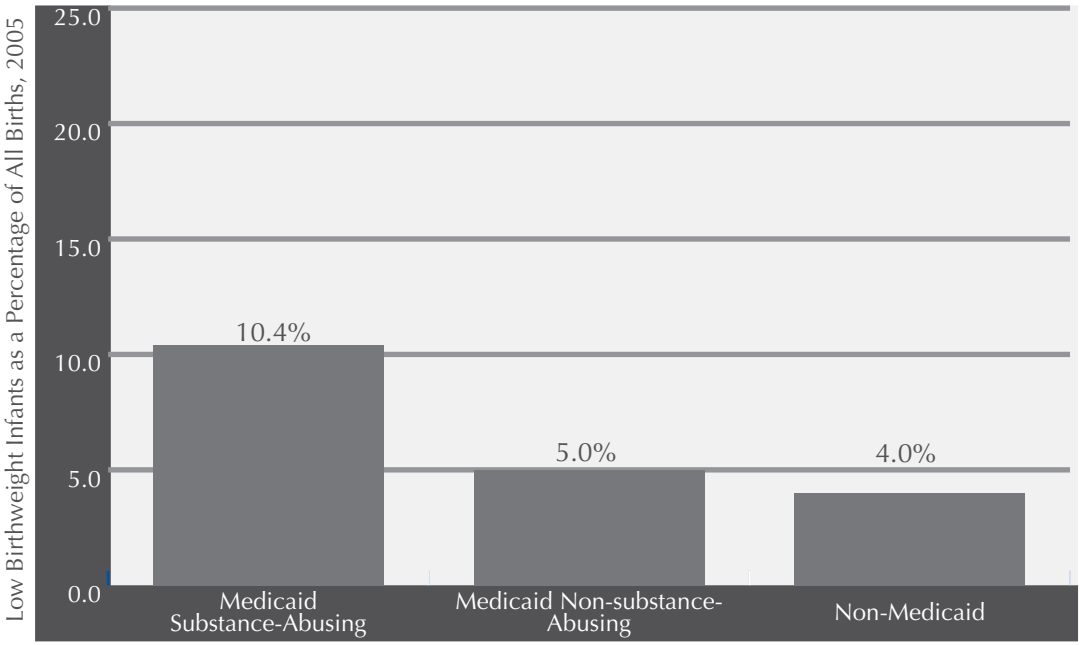
Teen pregnancy has long been associated with alcohol and other drug use. In a survey of women in Washington State who were 18 years old or younger at the time of their first pregnancy, almost one-quarter reported having used alcohol or another drug when they first became pregnant, and 36% reported that their partner used alcohol or drugs at that time.[1] Alcohol and drug use in pregnancy is closely associated with a range of health effects among children, including Fetal Alcohol Spectrum Disorders and mental retardation. Maternal age is also a significant risk factor for infant mortality.[2]

This graph indicates that the rate of births per thousand among teens ages 15-17 is lower in Washington State than the nation. However, the rate has risen significantly since 2005. In 2007, there were 2,217 live births to women ages 15-17 in Washington State, representing a 12.8% increase in two years.[3] It is estimated that teen pregnancy (ages 19 and younger) cost Washington State $115 million in 2004 ($43 million in federal funds; $72 million in state and local funds). Nationally, the cost is estimated annually at $9.1 billion.[4]



[1] Boyer, D., & Fine D. "Sexual Abuse as a Factor in Adolescent Pregnancy and Child Maltreatment," *Family Planning Perspectives* 241(1), 1992, 4-12.
[2] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-3. Washington, DC: 2000.
[3] Center for Health Statistics, Washington State Department of Health, 2009.
[4] Hoffman, S. *By the Numbers: The Public Costs of Teen Childbearing*. Washington, DC: National Campaign to Prevent Teen Pregnancy, 2006.

# Infants Born to Low-Income, Substance-Abusing Women are Much More Likely to Be Low Birthweight.




Source: First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services, 2009.

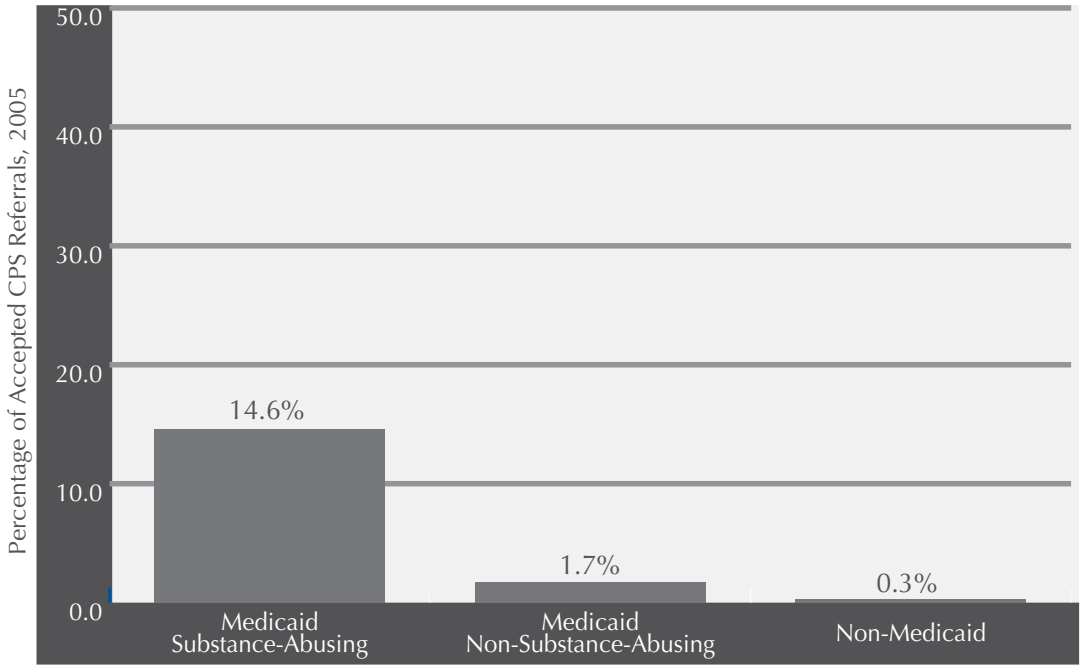
Infants born to low-income, substance-abusing mothers are substantially more likely to be born with low birth weight (LBW), weighing less than 2,500 grams (5 pounds, 8 ounces). This includes those who are born prematurely and those whose intrauterine growth is retarded. LBW is associated with long-term disabilities, including cerebral palsy, autism, mental retardation, hearing impairments, and other developmental problems.[1]

Two Washington studies reported fewer LBW births among substance-abusing women who received chemical dependency treatment during pregnancy.[2]



[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4; 16-34. Washington, DC: 2000.
[2] Krohn, M. "Preliminary Findings for MOMS Project," *Focus, 1993*. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse. Shrager, L., Kenny, F., and Cawthon, L. *Substance Abuse Treatment for Female DASA Clients: Treatments, Birth Outcomes, and Demographic Profiles*. Olympia, WA: Washington State Department of Social and Health Services, Office of Research and Data Analysis, 1993.

# Infants Born to Low-Income Substance-Abusing Women are More Likely to Be Reported to Child Protective Services as Being at High Risk of Imminent Harm.



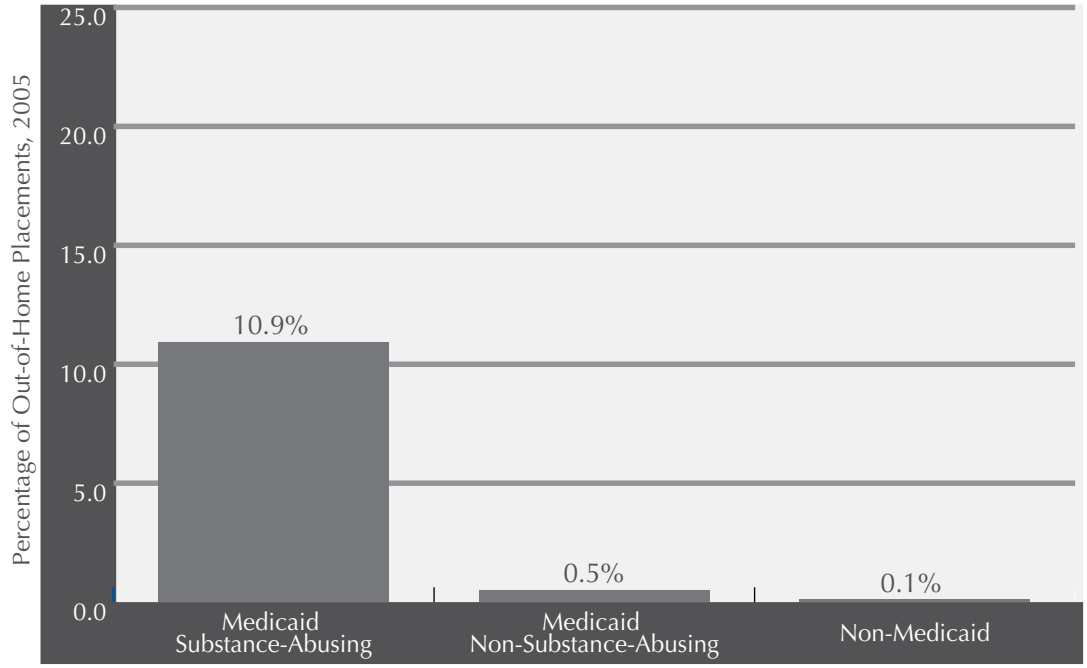

Source: First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services, 2009.

Researchers have consistently found an association between alcohol and other drug abuse and virtually all forms of interpersonal violence, including child abuse and neglect. The 2007 Child Maltreatment Report from the federal Children's Bureau found 794,000 substantiated cases of child maltreatment nationwide. Some 59% of reports were for neglect; 11% for physical abuse; 9% for sexual abuse; and 4% for psychological abuse. An estimated 1,760 children died due to child abuse or neglect in 2007, including 27 in Washington State.[1]



[1] Children's Bureau, *Children Maltreatment 2007*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, 2009.

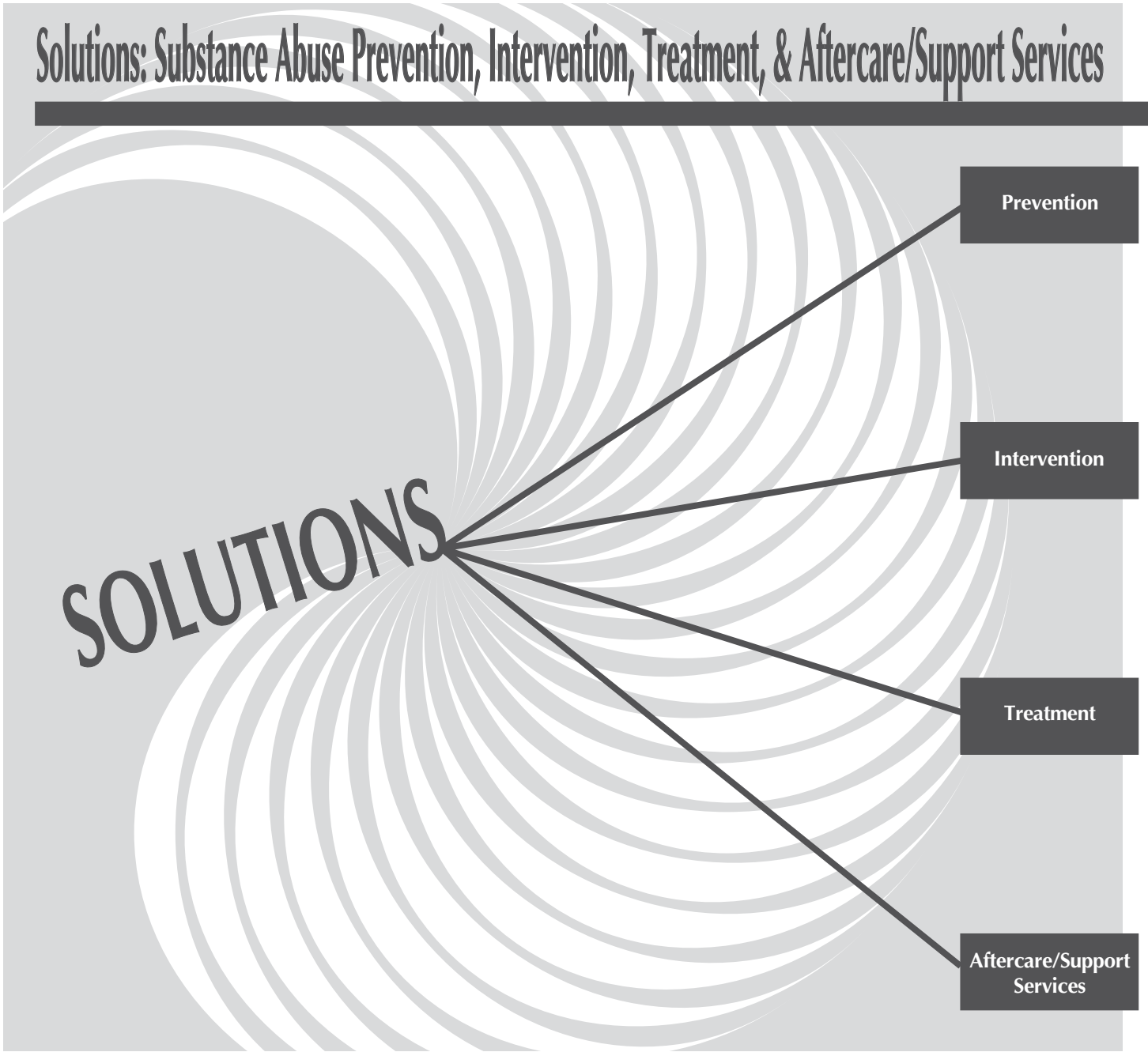
# Infants Born to Low-Income, Substance-Abusing Women are More Likely to Be Placed Out of Home.




Source: First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services, 2009.

Women receiving Medicaid who are substance abusers are some 20 times more likely to have their infants removed from their care by Child Protective Services and placed out-of-home than women on Medicaid who are not substance abusers. Researchers have consistently found an association between alcohol and other drug abuse and virtually all forms of interpersonal violence, including child abuse and neglect.

# Solutions: Substance Abuse Prevention, Intervention, Treatment, & Aftercare/Support Services



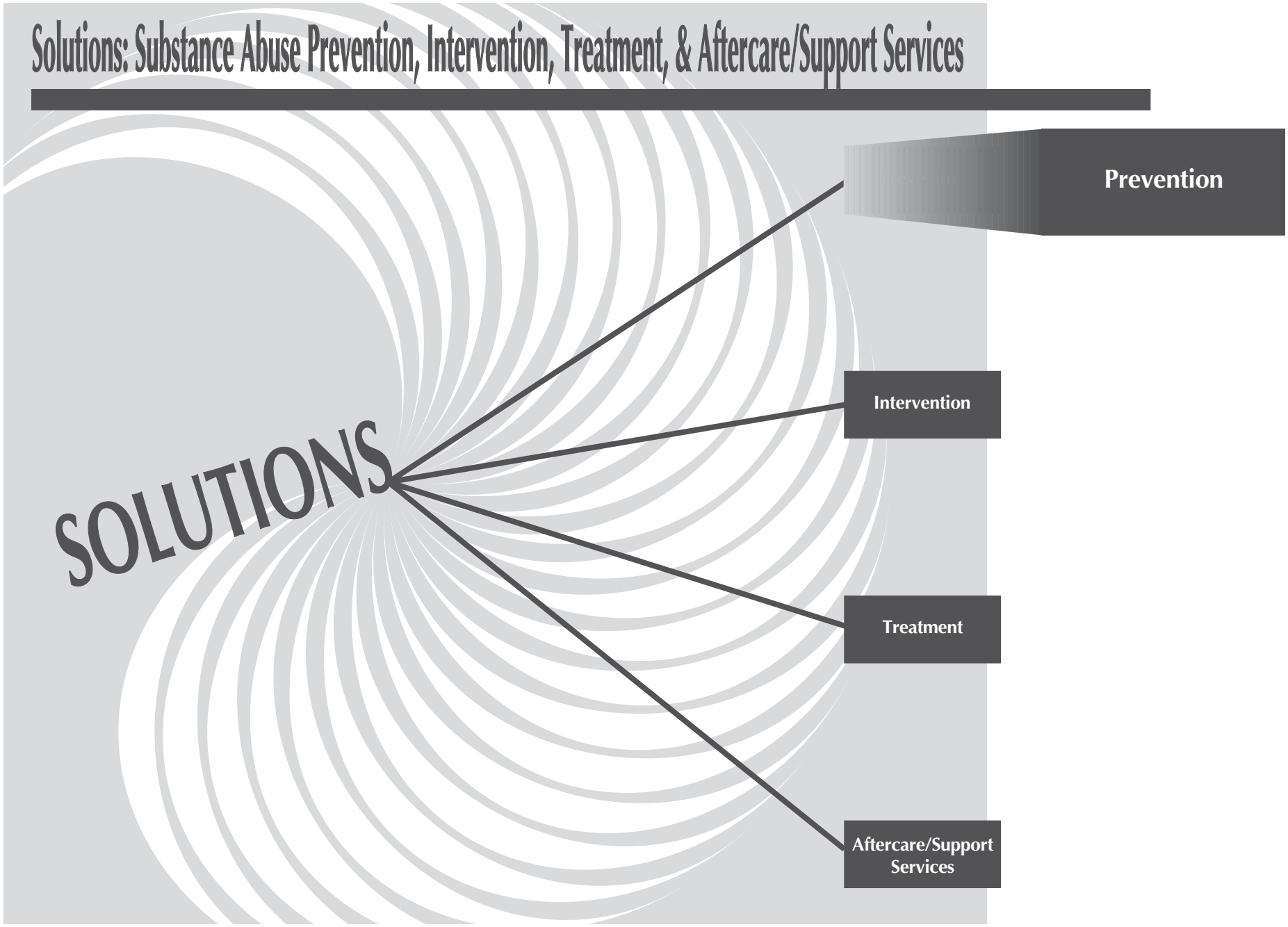
# Introduction

State Law RCW 70.96A identifies the Division of Alcohol and Substance Abuse (DASA) (now the Division of Behavioral Health and Recovery - DBHR) as the "single state" agency for planning and delivery of substance abuse treatment and prevention services. All public substance abuse services funded by state or federal funds are either managed by DBHR or operate in coordination with DBHR (for example, services provided by the Department of Health, the Department of Licensing, the Department of Corrections, and the Office of Superintendent of Public Instruction).

DBHR does not provide direct prevention or treatment services, but rather, provides these services through contracts with county governments, Indian tribes, and non-profit service providers. The largest portion of available federal and state funds are contracted through county and tribal governments. Each biennium, DBHR develops a plan for program development and prevention, intervention, treatment, and aftercare service strategies.

County governments and tribes are awarded prevention and treatment funds on the basis of a formula established by DBHR in coordination with these governmental units. Counties and tribes are expected to conduct a needs assessment for prevention and treatment needs, based on available funding, and submit a plan to DBHR. Contracts for community-based prevention and treatment services are written to include work statements specifying the activities which will be provided under the contracts.

# Solutions: Substance Abuse Prevention, Intervention, Treatment, & Aftercare/Support Services



# Prevention

Washington's youth are faced with choices every day that may result in a variety of problem behaviors. Among the most dangerous of those behaviors is the abuse of alcohol, tobacco, and other drugs. It is the Division of Behavioral Health and Recovery's (DBHR) policy that any use of illicit drugs and the inappropriate use of legal drugs, including alcohol, are considered drug abuse. DBHR's goal for the majority of prevention programs it supports is two-fold: programs should act to *delay* the onset of alcohol and tobacco use, and also act to *prevent* the abuse of alcohol, tobacco, and other drugs.

DBHR contracts with counties and tribes to provide services at the community level. The Risk and Protective Factor Framework is the cornerstone of all program investments.

## *Risk and Protective Factor Framework*

Over the past two decades, much research has focused on determining how drug abuse begins and how it progresses. Just as medical researchers have found risk factors for heart disease (e.g., lack of exercise, smoking), prevention research has identified a set of risk factors and protective factors related to drug abuse. The more risk factors a child is exposed to, the more likely the child will abuse drugs, alcohol, or tobacco. Some risk factors may be more powerful than others at certain stages in development, such as peer pressure during the teenage years. At each stage, risks exist that can be mitigated through prevention intervention. Early childhood risks, such as aggressive behavior, can be changed or prevented with family, school, and community interventions that focus on helping children develop appropriate, positive behaviors. If not addressed, negative behaviors can lead to more risks, such as academic failure and social difficulties, which, in turn, put children at further risk for drug abuse later in life.

Many risk factors associated with adolescent substance abuse are also tied to other problem behaviors, including: delinquency, teen pregnancy, school dropout, violence, and depression/anxiety. While the primary focus of prevention programs supported by DBHR is substance abuse, addressing its risk factors will likely impact multiple problem behaviors.

Not every young person who is exposed to multiple risks becomes a substance abuser, juvenile delinquent, school dropout, or teen parent. There are conditions – known as protective factors – that can counter the risks. Protective factors are buffers in the lives of young people that either reduce the impact of the risk or change the way a person responds to the risk. A strong parent-child bond is an example of a protective factor. When children are strongly attached to positive families, friends, schools, and communities, they are more likely to be committed to achieving the goals valued by these groups and are less likely to develop problems as a teenager.

Risk and protective factor-focused prevention programs are based on a simple premise: to prevent a substance abuse problem, we must identify those factors that increase the likelihood of that problem developing and then intervene in ways that reduce the risk. At the same time, we must identify protective factors that buffer individuals from the risks present in their environments and then find ways to strengthen that protection.

Risk and protective factors fall into four domains. Research indicates that by reducing risk factors and enhancing protective factors in each of the domains, the likelihood that youth will engage in or experience problem behaviors can be substantially reduced.

The four domains are: community, family, school, and individual/peer.

# Risk Factors and Adolescent Problem Behavior

| RISK FACTORS BY DOMAIN ▼ | Substance Abuse | Delinquency | Teen Pregnancy | School Dropout | Violence | Depression/ Anxiety |
|---|---|---|---|---|---|---|
| ***Community*** | | | | | | |
| Availability of Drugs | ■ | | | | ■ | |
| Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime | ■ | ■ | | | ■ | |
| Transitions and Mobility | ■ | ■ | | ■ | | ■ |
| Low Neighborhood Attachment and Community Disorganization | ■ | ■ | | | ■ | |
| Extreme Economic Deprivation | ■ | ■ | ■ | ■ | ■ | |
| ***Family*** | | | | | | |
| Family History of the Problem Behavior | ■ | ■ | ■ | ■ | ■ | ■ |
| Family Management Problems | ■ | ■ | ■ | ■ | ■ | ■ |
| Family Conflict | ■ | ■ | ■ | ■ | ■ | ■ |
| Favorable Parental Attitudes and Involvement in the Problem Behavior | ■ | ■ | | | ■ | |
| ***School*** | | | | | | |
| Academic Failure Beginning in Late Elementary School | ■ | ■ | ■ | ■ | ■ | ■ |
| Lack of Commitment to School | ■ | ■ | ■ | ■ | ■ | |
| ***Individual/Peer*** | | | | | | |
| Early and Persistent Antisocial Behavior | ■ | ■ | ■ | ■ | ■ | ■ |
| Rebelliousness | ■ | ■ | | ■ | | |
| Friends Who Engage in the Problem Behavior | ■ | ■ | ■ | ■ | ■ | |
| Favorable Attitudes Toward the Problem Behavior | ■ | ■ | ■ | ■ | | |
| Early Initiation of the Problem Behavior | ■ | ■ | ■ | ■ | ■ | |
| Constitutional Factors | ■ | ■ | | | ■ | ■ |
| Gang Involvement | ■ | ■ | | | ■ | |

Source: Social Development Research Group, University of Washington.

# DBHR Prevention Programs Achieve Cost Offsets.

***Funds spent on prevention services are a sound investment in reducing taxpayer burdens in future years.***

Research conducted by the Washington State Institute for Public Policy (WSIPP) in 2004 provides a cost-benefit analysis and comparison of prevention programs. By and large, prevention programs save money through reduced costs associated with alcohol abuse and drug addiction, criminal justice, and health care. These cost savings are realized over the life of the participant.[1]

Division of Behavioral Health and Recovery (DBHR) prevention providers utilize many of the programs researched, as described on the following pages. By selecting programs with proven research results behind them, DBHR prevention providers save Washington State taxpayers millions of dollars.

Several thousand additional participants were in programs not analyzed in the WSIPP study. All DBHR prevention programs conform to the standards of the federal Center for Substance Abuse Prevention's *Principles of Substance Abuse* Prevention[2] to ensure quality programming.

[1] Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth*. Olympia, WA: Washington State Institute for Public Policy, 2004.
[2] Center for Substance Abuse Prevention. *Principles of Substance Abuse Prevention*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Division of Knowledge Development and Education, 2001. Details of the principles can be found at www.samhsa.gov/centers/csap/modelprograms/pdfs/pubs_Principles.pdf

# DBHR Prevention Programs Save the State Millions of Dollars Over the Lifetimes of the Participants.

**SFY 2009**

| Program Name | Net Lifetime Cost Benefit per Participant* | DASA Participants | Total Lifetime Cost Benefit** |
|---|---|---|---|
| All Stars | $120 | 207 | $24,840 |
| CASASTART | ($610.00) | 38 | -$23,180 |
| Guiding Good Choices/Preparing for the Drug Free Years | $6,918 | 322 | $2,227,596 |
| Home Visiting | $6,077 | 7 | $42,539 |
| Life Skills Training Program | $717 | 5,910 | $4,237,470 |
| Mentoring: Big Brothers/Big Sisters | $2,822 | 37 | $104,414 |
| Parents as Teachers | $800 | 12 | $9,600 |
| Project ALERT | $54 | 2,190 | $118,260 |
| Project Northland | $1,423 | 327 | $465,321 |
| Strengthening Families Program: Ages 6-11 | $485 | 365 | $177,025 |
| Strengthening Families Program: Ages 10-14 | $5,805 | 955 | $5,543,775 |

**Total: $19,144,390**

Research conducted by the Washington State Institute for Public Policy (WSIPP) in 2004 provides a cost-benefit analysis and comparison of prevention programs. By and large, prevention programs save money through reduced costs associated with alcohol use and drug addiction, criminal justice, and health care. These cost savings are realized over the life of the participant.[1] By multiplying the cost benefit per participant by the number of participants in these Division of Behavioral Health and Recovery-funded programs in SFY 2009, the total lifetime cost benefit to the state is estimated at $19 million.

*Source: Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth.* Olympia, WA: Washington Institute for Public Policy (WSIPP), 2004.
** Calculated by multiplying the number of participants enrolled in each program by the cost savings per participant listed in the WSIPP report.

[1] Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth.* Olympia, WA: Washington State Institute for Public Policy, 2004.

# DBHR Prevention Programs Save the State Money.

The following programs found to provide significant cost benefits to taxpayers by the Washington State Institute on Public Policy[1] are being implemented in the state:

**All Stars** reinforces the belief that risky behavior is not normal or acceptable by the adolescent's peer group. It also cultivates the belief that risky behavior does not fit with the youth's personal ideals and future aspirations, creates strong voluntary personal and public commitments to not participate in risky behaviors, and strengthens relationships between the adolescent, social institutions, and family.

**Big Brothers/Big Sisters** is a mentoring program which matches an adult volunteer to a child, with the expectation that a caring and supportive relationship will develop. Support of that match through ongoing supervision and monitoring by a professional staff member is an important component.

**CASASTART** (Striving Together to Achieve Rewarding Tomorrows) is a community-based, school-centered substance abuse and violence prevention program aimed at high-risk 8-13-year-olds, their families, and the neighborhoods in which they live. The program brings together key stakeholders in the community – schools, law enforcement agencies, social services and health organizations – and uses intensive case management to work with youth.

**Guiding Good Choices™,** formerly known as Preparing for the Drug Free Years, is a multi-media program that provides parents of children in 4th through 8th grades the knowledge and skills they need to guide their children through early adolescence. The program aims to strengthen and clarify family expectations for behavior, enhance the conditions that promote bonding in the family, and teach skills to parents and children to successfully meet the expectations of their family and to resist alcohol, tobacco, and other drug use.

**Home Visiting** provides a bridge between a parent with a young child and the outside world by way of a visitor who cares about child-raising. The visitor may provide cognitive information, emotional support, or both. Visitors can be nurses, social workers, preschool teachers, psychologists, or paraprofessionals.

**LifeSkills® Training** is a 3-year prevention curriculum designed to address a wide range of risk and protective factors by teaching general personal and social skills in combination with drug resistance skills and normative education. It is intended for middle school or junior high students.

**Parents as Teachers** is an early childhood parent education and family support program serving families from pregnancy through kindergarten. The program provides personal visits with certified parent educators, group meetings with other parents, developmental screenings, and linkages to community resources.

**Project ALERT** is a school-based, social resistance approach to drug abuse prevention. The curriculum specifically targets tobacco, alcohol, and marijuana use.

# DBHR Prevention Programs Save the State Money.

**Project Northland** consists of social-behavioral curricula in schools, peer leadership (designed to increase peer pressure resistance and social competence skills), parental involvement/education, and community-wide taskforce activities aimed at changing the larger environment.

**Project SUCCESS** (Schools Using Coordinated Community Efforts to Strengthen Students) provides a full range of substance use prevention and early intervention services. It places highly trained professionals in schools to work with high-risk youth 14-18 years old.

**Strengthening Families Program** (SFP) involves elementary school-aged children (6 to 11 years old) and their families in family skills training sessions. SFP uses family systems and cognitive-behavioral approaches to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems. It builds on protective factors by: improving family relationships, improving parenting skills, and increasing the youth's social and life skills.

**The Strengthening Families Program** (ages 10-14), resulted from an adaptation of the Strengthening Families Program (SFP). Formerly called the Iowa Strengthening Families Program, the long range goal of the curriculum is reduced substance use and behavior problems during adolescence. Intermediate objectives include improved skills in nurturing and child management by parents, improved interpersonal and personal competencies and pro-social skills among youth.



[1] Aos, S., et al. *Benefits and Costs of Prevention and Early Intervention Programs for Youth.* Olympia, WA: Washington State Institute for Public Policy, 2004.

# School-Based Prevention Stratagies

Many of the evidence-based prevention practices used across Washington State are based in schools, usually as part of the health education curriculum. Schools make the investment in time and resources that prevention programs require because of the link between substance use and academic outcomes. The direction of that link is not clear. That is, researchers cannot say that substance use causes academic problems, nor that academic problems lead to substance use. The relationship is more complex than that, and it likely changes at different grade levels as challenges change. However, research has demonstrated that students who initiate substance use before seventh grade are at higher risk of school failure, poor academic achievement, and school dropout.[1]

Prevention programs that are best practices used with younger children focus on social-emotional competence, promoting skills to inhibit impulsive behavior, regulate feelings, and correctly interpret the perceptions of others. Children who do not master these developmentally appropriate social tasks may develop behaviors that put them at considerable risk for later problems such as delinquency, substance abuse, and school dropout.[2]

Best-practice middle school programs also focus on social competence. Competence-enhancement approaches to prevention work with the assumption that adolescents lacking in social skills are more susceptible to influences that promote drug use, and may be motivated to use drugs as an alternative to more adaptive coping strategies.[3] These programs emphasize the teaching of generic social and personal skills such as communication, assertiveness, decision-making, goal-setting, self-control, and coping. The same skills that help youth to resist drug use help them to maintain commitment to school and other pro-social behaviors.

[1]Ellickson, P., Tucker, J., & Klein, D. "High-Risk Behaviors Associated with Early Smoking: Results from a 5-Year Follow-Up, "*Journal of Adolescent Health* 28, 2001; Fleming, C., et al., "Do Social and Behavioral Characteristics Targeted by Preventive Interventions Predict Standardized Test Scores and Grades?" *Journal of School Health* 75, 2005.
[2]Flory, K., et al. "Relation Between Childhood Disruptive Behavior Disorders and Substance Use and Dependence Symptoms in Young Adulthood: Individuals with Symptoms of Attention-Deficit/Hperactivity Disorder are Uniquely At Risk," *Psychology of Addictive Behaviors* 17, 2003; Greenberg. M., et al., "The PATHS Curriculum: Theory and Research on Neuro-Cognitive Development and School Success," in Zins, J., Weisberg, R., & Walber. J. (eds.) *Building School Success on Social and Emotional Learning*. New York: Teachers College Press, 2004; White, H., et al., "Psychopathology as a Predictor of Adolescent Drug Use Trajectories." *Psychology of Addictive Behaviors* 15, 2001.
[3]Botvin. G. "Preventing Drug Abuse in Schools: Social and Competence Enhancement Approaches Targeting Individual-Level Etiological Factors," *Addictive Behaviors* 25, 2000.

# School-Based Programs in Use in Washington State

**PAL® (Peer Assistance and Leadership)** includes the following: group and one-to-one peer tutoring and mentoring; facilitation of activities and group discussions on issues such as substance use and career choices; peer mediation and conflict resolution services; development and participation in community service projects. The programs seek to develop communication, decision-making, problem-solving, team and relationship building, confidentiality, and refusal skills.

**Positive Action** aims to improve the academic achievement and behavior of children and adolescents. It is intensive, with lessons at each grade level from kindergarten through 12th grade that are reinforced all day, school-wide, at home, and in the community.

**Second Step** is a classroom-based social skills program for preschool through junior high students. It aims to reduce aggressive behaviors and increase children's social-emotional competence.

**Sembrando Salud** is a culturally sensitive tobacco and alcohol use prevention program specifically adapted for migrant Hispanic youth and their families. The program enhances parent-child communication skills as a way of improving and maintaining healthy youth decision-making. It uses a school and family curriculum delivered by bilingual/bicultural college students.

**Storytelling for Empowerment** uses stories to pass on values and cultural identity and as such is a natural vehicle for nurturing protective factors in youth. It is school-based secondary prevention designed for club and classroom settings serving American Indian and Latino middle school youth.

**Too Good for Drugs (TGFD)** is a K-12 multifaceted, interactive social influence intervention. The program is a long-term intervention that builds skills sequentially with the intention of preventing substance use and promoting healthy decision-making and positive, healthy youth development. This program is designed to benefit everyone in the school by enhancing social and emotional competencies.

**Tutoring** improves academic success among elementary school students who have serious academic problems in reading and/or mathematics.

# Other Best and Promising Practices in Use in Washington State

**BASICS (Brief Alcohol Screening and Intervention of College Students)** is a preventive intervention aimed at students who drink alcohol heavily and have experienced or are at risk of experiencing alcohol-related problems, such as poor class attendance, missed assignments, accidents, sexual assault, and violence.

**Birth to Three** is designed for a broad range of parents with infants and young children (0-7 years of age). The mission is to strengthen families and promote the well-being of children through parent education and support.

**Communities Mobilizing for Change on Alcohol** works to change policies and practices of major community institutions in ways that reduce access to alcohol by teenagers. The intervention approach involves activating the citizenry of communities to achieve changes in local public policies.

**Communities That Care** provides research-based tools to help communities mobilize to promote the positive development of children and youth and to prevent adolescent problem behaviors that impede positive development, including substance abuse, delinquency, teen pregnancy, school dropout, and violence.

**Community Trials Intervention to Reduce High-Risk Drinking** is a multi-component, community-based program developed to alter alcohol use patterns of people of all ages (e.g., drinking and driving, underage drinking, binge drinking), and related problems.

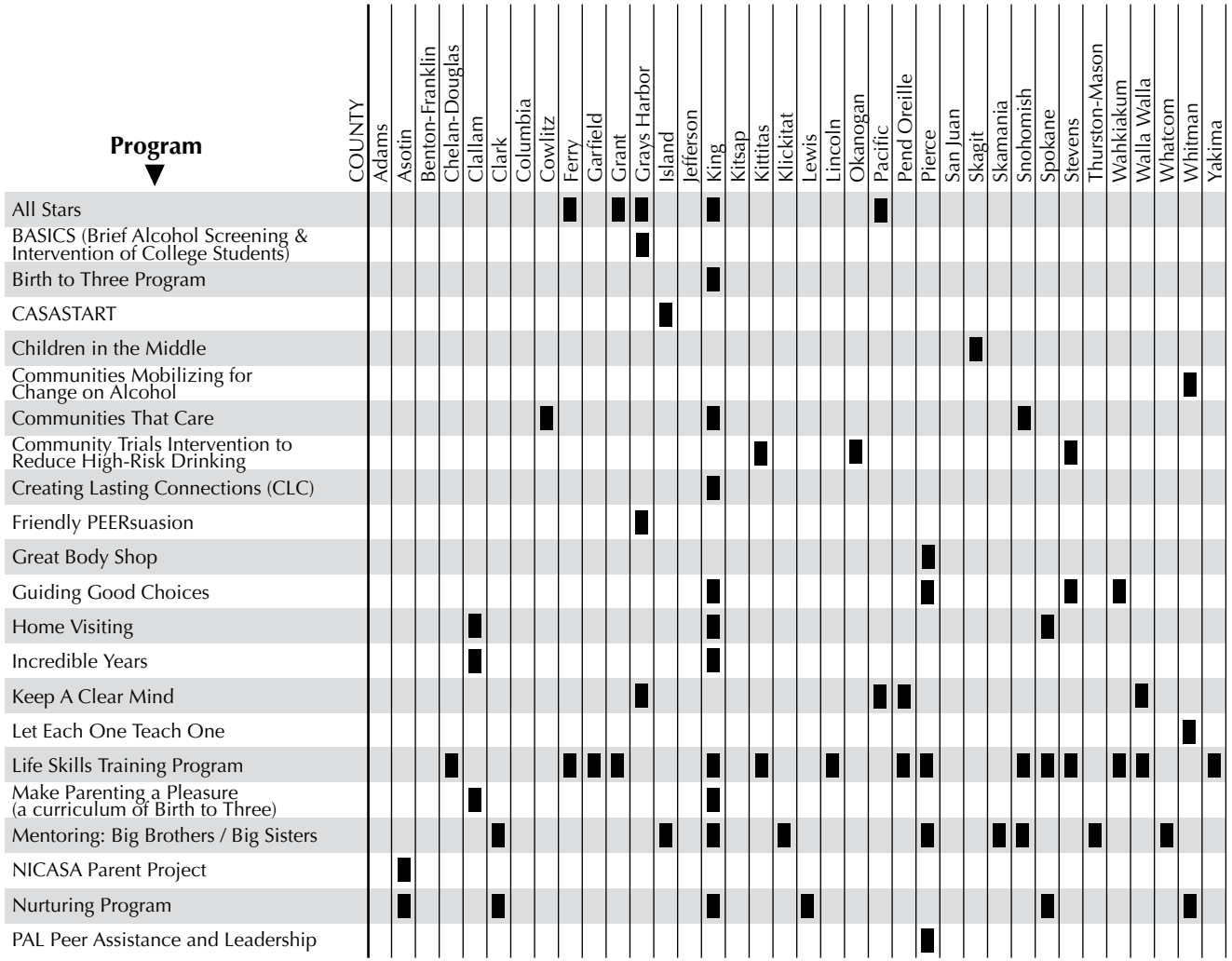
**Creating Lasting Connections (CLC)** is a comprehensive family strengthening curriculum that assists youth and families in high-risk environments to become strong, healthy, and supportive people.

**Houston Parent-Child Development Center** was developed to assist low-income, Mexican-American families in helping their children do well in school and foster intellectual and social competence. The program was designed to provide a wide range of educational and support services, to deliver these services in ways that are responsive to the families' poverty, and to be sensitive to people's culture.

**Incredible Years** is a family program designed to improve parents' communication skills with their children, learn limit-setting skills by means of nonviolent discipline techniques, improve their own problem-solving skills, and learn effective methods of anger management. For children, short term objectives include reduction of the frequency and number of conduct problems and improvement of pro-social skills.

# Prevention Best Practices By County

The table below displays prevention best practices being utilized in the 2007-2009 Biennium by each of Washington State's 39 counties:




Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.

# Prevention Best Practices By County

The table below displays prevention best practices being utilized in the 2007-2009 Biennium by each of Washington State's 39 counties:

| Program ▼ / COUNTY | Adams | Asotin | Benton-Franklin | Chelan-Douglas | Clallam | Clark | Columbia | Cowlitz | Ferry | Garfield | Grant | Grays Harbor | Island | Jefferson | King | Kitsap | Kittitas | Klickitat | Lewis | Lincoln | Okanogan | Pacific | Pend Oreille | Pierce | San Juan | Skagit | Skamania | Snohomish | Spokane | Stevens | Thurston-Mason | Wahkiakum | Walla Walla | Whatcom | Whitman | Yakima |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Parenting Skills Program | | | | | | | | | | | | | | | ■ | | | | | | | | | | | | | | | | | | | | | |
| Parenting Wisely | ■ | | | | ■ | | ■ | | | | ■ | | | | | | | ■ | | | | | | | | | | ■ | | | ■ | | | | | |
| Parents as Teachers | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ■ | | |
| Positive Action | | | | | | | | | | | | | | | | | | | | | | | | | | | | | ■ | | | | | | | |
| Project ALERT | ■ | | ■ | | | | | | | ■ | | ■ | | ■ | ■ | | | | | | | ■ | | | | | | | ■ | ■ | | | ■ | | | |
| Project Northland | | | | ■ | | | | | | | | | | | | | | | | | | | | | | | | | | | ■ | | | | | |
| Protecting You/Protecting Me | | | | | | | | | | | | | | | | | | | | ■ | | | | | | | | | | | ■ | | | | | |
| Retailer-Directed Interventions | | | | | | | | | | | | ■ | | | | | | | | | | | | | | | | | | | | | | | | |
| Say It Straight | | | | | | | | | | | | | | | | | | | | | | | | | | | | ■ | | | | | | | | |
| Second Step: A Violence Prevention Curriculum | | | | ■ | | | | | ■ | | | | | | | | | | | ■ | | | | | | | | ■ | | | | | | | |
| Sembrando Salud | | | | | | | | | | | | | | | | | | | | | | | | | | ■ | | | | | | | | | | |
| Staying Connected with Your Team (formerly Parents Who Care) | | | | | | | | | | | | | | | ■ | | | | | | ■ | | ■ | | | | | | | | | | | | | |
| Strengthening Families Program | | | ■ | | ■ | ■ | | ■ | | | | | | | | | | | | | | | | | | | | | | | | | | | | ■ |
| Strengthening Families Program: 10-14 | | ■ | ■ | ■ | | | | | ■ | | ■ | ■ | | | | ■ | | ■ | ■ | | ■ | | | ■ | ■ | ■ | | ■ | ■ | ■ | ■ | | | ■ | ■ | ■ |
| Strengthening Multi-Ethnic Families & Communities | | | | | | | | | | | | | | | ■ | | | | | | | | | ■ | | | | ■ | | | | | | | | |
| Tribes Learning Communities | | | | | | | | | | | | | | | | | | | | | | | | ■ | | | | | | | | | | | | |
| Tutoring | | | | | | | | | | ■ | | | | | | ■ | | | | | | | | ■ | | | | ■ | ■ | | | | | | | |

Source: Data compiled from Division of Alcohol and Substance Abuse Performance-Based Prevention System.

# Using Prevention Science

Most participants enrolled in prevention programs funded by the Division of Behavioral Health and Recovery (DBHR) receive services proven to be effective in reducing substance use and other problem behaviors. DBHR stresses the use of strategies scientifically proven to reduce substance abuse, while at the same time recognizing the importance of local innovation to develop programs for specific populations or emerging problems.

## *Best Practices*

Best practices are those strategies, activities, or approaches that have been shown through substantial research and evaluation to be effective at preventing and/or delaying substance abuse. DBHR utilizes best practices listed by the Center for Substance Abuse Prevention, Western Center for the Application of Prevention Technologies. This list includes programs deemed research-based by scientists and researchers at: National Institute of Drug Abuse; Center for Substance Abuse Prevention; National Center for the Advancement of Prevention; Office of Juvenile Justice and Delinquency Prevention; and the federal Centers for Disease Control and Prevention.

## *Promising Practices*

Promising practices are programs and strategies that have some quantitative data indicating positive outcomes in delaying substance abuse over a period of time, but do not have enough research or replication to support generalizable outcomes.

## *Innovation*

Innovative programs and strategies are developed locally to address a specific need or issue. Development is guided by proven principles of effectiveness. These programs have generally not undergone the rigorous scientific review of a best practice.

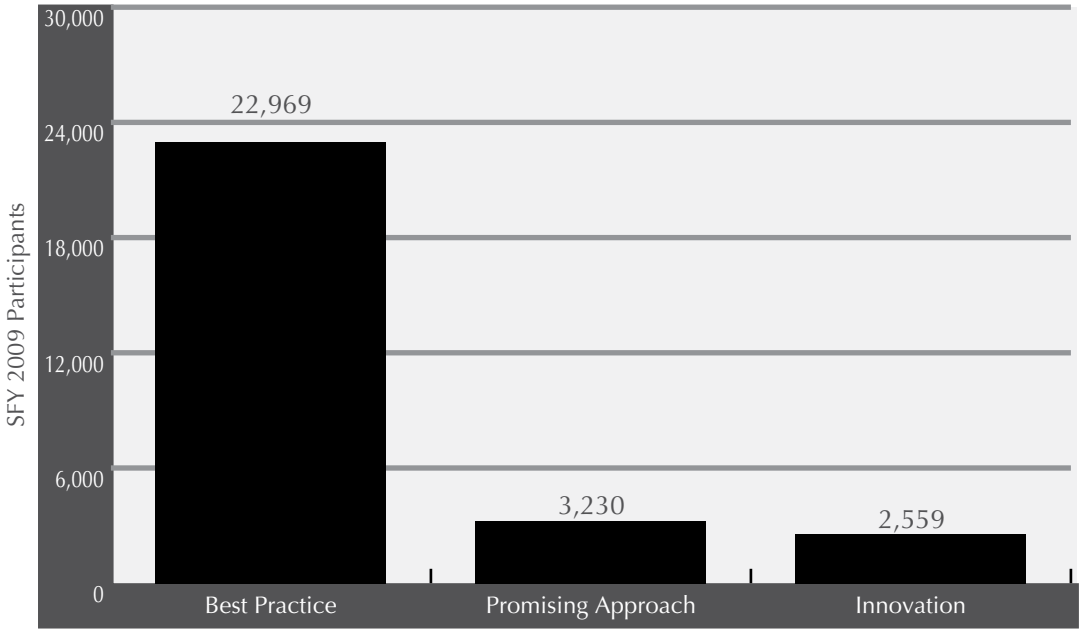
## *Principles of Effective Substance Abuse Prevention*

In Washington State, DBHR contracts with county prevention providers. Providers are required to use scientifically based best or promising practices for a least 50% of programming. In the 2007-2009 Biennium, 64% of DBHR-funded prevention programs represented best or promising practices. When choosing to design and implement other programs, providers are required to refer to the federal Center for Substance Abuse Prevention's *Principles of Substance Abuse Prevention* and apply these principles to their work in communities.[1]



[1] Center for Substance Abuse Prevention. *Principles of Substance Abuse Prevention*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Division of Knowledge Development and Education, 2001. Details of the principles can be found at www.samhsa.gov/centers/csap/modelprograms/pdfs/pubs_Principles.pdf

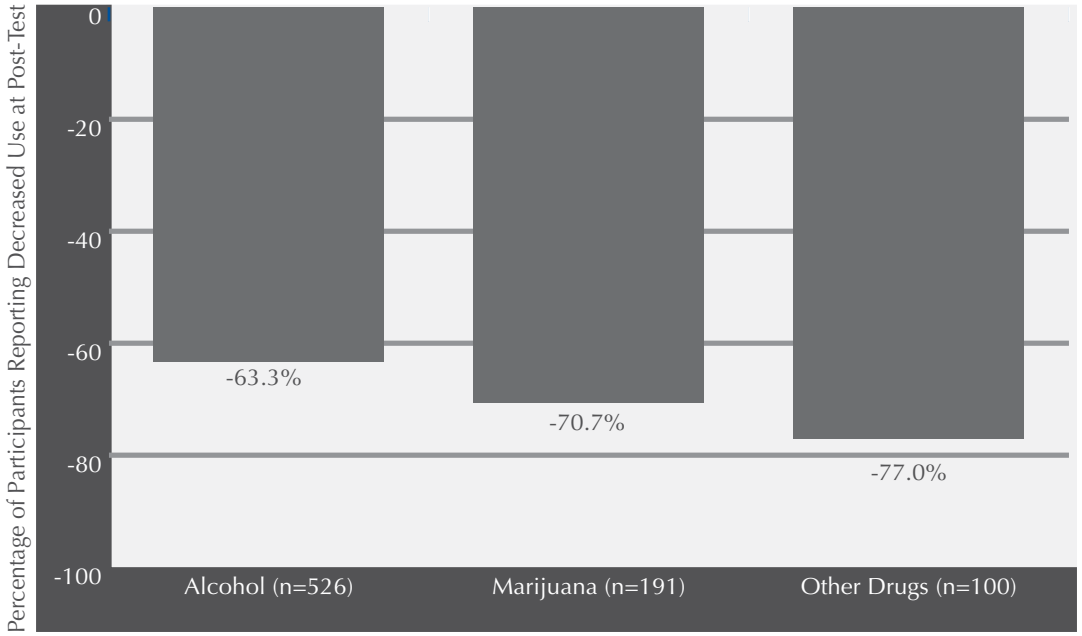
# The Majority of Participants in DBHR-Funded Recurrring Prevention Programs are in Programs Using Best Practices.




Source: Washington State Performance-Based Prevention System.

The Division of Behavioral Health and Recovery stresses the use of proven strategies to reduce substance abuse, while recognizing the importance of local innovation to develop recurring programs for specific populations or emerging problems. Best practices are strategies, activities, or approaches which have been shown scientifically to prevent and/or delay substance abuse. Promising practices have some quantitative data demonstrating positive outcomes, but not enough research or replication to support generalizable outcomes. Innovative programs or strategies are developed locally to address a specific need or issue.

# Following Participation in DBHR-Funded Prevention Programs, Alcohol, Marijuana, and Other Drug Use Among Youth Ages 12-17 Who Previously Used Declined Significantly.




Source: Performance Based Prevention System, Washington State Division of Alcohol and Substance Abuse, 2009.

DBHR-funded prevention services delivered through contracts with counties and tribes result in both decreased use and increased abstinence from alcohol and drug use use among participants ages 12-17. Between the pre-test of participants and the follow-up months after program completion in SFY 2005-2009, 30-day alcohol use among those previously reporting any use dropped by 23.5%, marijuana use by 44.8%, and use of other drugs by 81.3%. Even among those who continued to drink alcohol, 68% did not think it was acceptable for people their age to drink alcohol, and 54% thought there was at least some risk from drinking one or two drinks nearly every day. Similar results were reported among marijuana users. Note that the overwhelming majority (91.5%) of participants did not report any alcohol or drug use in the 30 days prior to receiving prevention services.[1]



[1] Performance Based Prevention System. Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2009.

# Statewide Prevention Services and Programs

The Division of Behavioral Health and Recovery (DBHR) funds statewide services primarily by way of interagency agreements and partnerships with state agencies and non-profit organizations. The following programs are either partially or fully funded by DBHR:

## *School-Based Prevention and Intervention Services Program*

The Office of Superintendent of Public Instruction (OSPI) administers a school-based program targeting students at risk for developing alcohol, tobacco, and other drug-related problems. During SFY 2009, more than 300 Prevention/Intervention Specialists implemented programs in nine Educational Service Districts and three school districts. These services were offered in all the regions of the state and were delivered to 12,388 kindergarten through twelfth grade students.

## *Healthy Youth Survey*

OSPI administers an adolescent health behavior survey every other year. Substance abuse prevalence and risk/protective factor data are generated from this survey and used by prevention planners and service providers throughout our state. The 2008 Healthy Youth Survey was the tenth time health-related attitudes and behaviors of Washington's public school students have been assessed. More than 211,000 students in elementary, middle, and high schools across the state participated in the survey.

## *Reducing Underage Drinking Initiative (RUaD)*

RUaD's goal is to prevent or reduce the consumption of alcohol by minors, especially through increased enforcement of underage drinking laws. The RUaD program has received annual block grant awards since 1998 from the federal Office of Juvenile Justice and Delinquency Prevention (OJJDP). The block grants have supported public education efforts, Liquor Control Board enhancements, a RUaD track and/or workshops at the State Prevention Summit, youth leadership activities, and community-based coalitions. In addition to the block grants, DASA is the recipient of three discretionary grants. These funds support the efforts of communities as they implement comprehensive approaches to the problem of underage drinking, with an emphasis on increasing law enforcement activity. The Washington State RUaD Coalition, with membership of 24 state agencies and statewide organizations, is actively pursuing its mission largely through the efforts of two subcommittees. One is focused on communication strategies to change parental norms about their children's alcohol use, including the development and improvement of a website for parents and people who with them – www.starttalkingnow.org ; the second is developing community action tools to address alcohol industry marketing to youth and other environmental issues. A recent development is the Prevention and Industry Partnership, which works on issues that cross the usual divide between these interests and can better be addressed through cooperation rather through adversarial approaches.

## *Reducing Access to Tobacco Products (Synar Regulation)*

The Substance Abuse Prevention and Treatment (SAPT) block grant requires that states focus on reducing youth access to tobacco products through retail outlets. The Synar Regulation requires that states reach and maintain a maximum 20%

non-compliance rate as measured through compliance checks. Washington's success in meeting the Synar requirements is due to DBHR's positive and effective relationship with two other state agencies, the Department of Health (DOH) and the Liquor Control Board. DOH develops a randomized list of tobacco retailers in the state and then asks local health jurisdictions to implement unannounced youth access compliance checks. Local health jurisdictions are responsible for implementing the Synar compliance checks assigned to them through the statewide sampling. They report the results of the checks back to DOH. In 2008, the non-compliance rate was 15.4%.

## *College Coalition for Substance Abuse Prevention*

The College Coalition was established to develop, implement, and continue substance abuse prevention programming at all college and university campuses in Washington State. The Coalition meets three or more times each academic year, and sponsors training opportunities that support the findings from the survey of college and university student alcohol and other drug use published in 2004. Beginning in 2009, the University of Washington took over responsibility for facilitating the Coalition.

## *Children's Transition Initiative (CTI)*

DBHR established the Children's Transition Initiative (CTI) to encourage prevention providers to address the risk and protective factors in children transitioning from grade school to middle school. CTI counties include Ferry, Grant, Lincoln, San Juan, Snohomish and Spokane. These counties have developed mentoring programs based on a nationally recognized model. In addition, parents and families are enrolled in family strengthening programs. Since 2005, CTI has used an innovative evaluation strategy for the mentoring component of the program, and found that high quality mentoring relationships were formed, and youth participants showed improvement in a variety of attitudes and behaviors, including school performance.

## *Alcohol/Drug Clearinghouse*

DBHR finds the statewide Alcohol/Drug Clearinghouse to provide a wide range of timely resource material and information for Washington State residents, including non-English-speaking individuals and persons with disabilities. The Clearinghouse maintains a statewide toll-free phone line for requesting resources, including a system for receiving requests from the hearing impaired community, as well as a website and video lending library. In 2008, the Clearinghouse distributed more than 510,000 resource items, and staffed 74 exhibits. The Clearinghouse also publishes an electronic newsletter to communicate federal, state, and local prevention news and activities/campaigns to individuals and organizations. For more information about Clearinghouse resources, call 1-800-662-9111.

## *Exemplary Substance Abuse Prevention Awards*

The Washington State Exemplary Substance Abuse Prevention Awards Program recognizes outstanding prevention programs, individuals working in the field, youth, and media organizations that support prevention efforts. A committee reviews and

selects awardees from six different categories. The state awards process is designed to coordinate with the existing national awards process, with the goal of identifying programs that could be encouraged to apply at the national level. The awards process is conducted in cooperation with the Office of the Lieutenant Governor, the Citizens Advisory Council on Alcoholism and Drug Addiction, and the Washington Interagency Network.

## *Public Education and Communications Program*

The goal of the Public Education and Communications Program is to increase awareness of the negative social and health consequences that can result from the misuse of alcohol, tobacco, and other drugs, and problem and pathological gambling, and of resources and services that are available from DBHR. Communication priorities are to support efforts to reduce underage drinking, increase awareness of DBHR-funded treatment and recovery resources, and raise awareness of problem gambling. The Program implements statewide public education campaigns, develops and disseminates publications and news releases, and provides social marketing training and tools to providers and other partners. In 2008, DBHR's media partners donated more than $300,000 in advertising for communications campaigns to prevent underage drinking and other drug use. In response to news releases, about 40 news stories appeared about DBHR-funded research and services.

## *Washington State Prevention Summit*

DBHR provides coordinates an annual statewide substance abuse prevention conference, for which it proves primary funding. The goal of the Prevention Summit is to provide an enriching training and networking opportunity for youth, volunteers, and professionals who work toward the prevention of substance abuse and violence. The Summit reaches both those who are new to the field and those highly experienced, and builds on successful prevention practices in Washington State. Prevention, treatment, and mental health professionals, community members, school personnel, parents and students, members of faith-based organizations and the law enforcement community all attend. The Summit represents a major collaborative effort among state and local agencies, and student and community organizations.

## *Drug Free Communities*

In 2008, twenty-eight community coalitions in Washington State received annual grants of up to $125,000 each from the federal Drug Free Communities Support Program, funded by the White House Office of National Drug Control Policy. The program's goal is to reduce substance abuse by engaging coalitions in effective community-wide change initiatives, based on the thesis that local problems require local solutions. A broad range of diverse communities – urban/rural, Eastern/Western Washington – are funded.

The coalitions have formed a network to share information and training opportunities. DBHR hosts a meeting for member coalitions each fall during the Prevention Summit, which is also attended by the federal staff from the federal Center for Substance Abuse Prevention that oversees the program. DBHR provides annual workshops to build capacity for coalitions to apply for funding, and supports existing coalitions through training and technical assistance.

## *State Prevention Framework-State Incentive Grant (SPF-SIG)*

In October 2004, Washington State received a Strategic Prevention Framework-State Incentive Grant (SPF-SIG) through the Center for Substance Abuse Prevention for $2.35-million per year for five years. The goals of the grant are to: 1) Prevent the onset and reduce the progression of substance abuse, including underage drinking; 2) Reduce substance-related problems in communities; 3) Build prevention capacities and infrastructure at state and community levels; and, 4) Implement a process of infusing data across all SPF steps for improved decision-making.

The project is focused on utilizing the five-step Strategic Prevention Framework (SPF) planning model to reduce underage drinking in 12 communities and on enhancing agency cooperation at the state level. The project is being evaluated closely using a randomized treatment and control group study design using a number of data sources, including the statewide Healthy Youth Survey and other community-specific information such as law enforcement data.

# Underage Drinking

# The U.S. Surgeon General Issues Call for Action on Underage Drinking

In 2007, noting that underage alcohol consumption is a widespread and persistent public health and safety problem, Acting Surgeon General Kenneth P. Moritsugu, M.D., M.P.H., issued a "Call to Action to Prevent and Reduce Underage Drinking." The 107-page, science-based document summarizes the latest research on underage drinking, and makes particular note of the emerging body of research on the negative effects of underage alcohol use on adolescent brain development. The Call to Action is based on five overarching principles:

- Underage alcohol use is a phenomenon that is directly related to human development.[1]
- Factors that protect adolescents from alcohol use as well as those that put them at risk change during the course of adolescence.
- Protecting adolescents from alcohol use requires a comprehensive, developmentally based approach.
- The prevention and reduction of underage drinking is the collective responsibility of the nation.
- Underage alcohol use is not inevitable.

The Surgeon General outlined six goals for the nation:

1. Foster changes in American society that facilitate health adolescent development and that help prevent and reduce underage drinking.
2. Engage parents and other caregivers, schools, communities, all levels of government, all social systems that interface with youth, and youth themselves in a coordinated national effort to prevent and reduce underage drinking and its consequences.
3. Promote an understanding of underage alcohol consumption in the context of human development and maturation that takes into account individual adolescent characteristics as well as environmental, ethnic, cultural, and gender differences.
4. Conduct additional research on adolescent alcohol use and its relationship to development.
5. Work to improve public health surveillance on underage drinking and on population-based risk factors for this behavior.
6. Work to ensure that policies at all levels are consistent with the national goal of prevention and reducing underage alcohol consumption.

The full report, which includes the rationale, challenges associated with combating underage drinking, and specific strategies for achieving each goal, can be found at www.surgeongeneral.gov/topics/underagedrinking/calltoaction.pdf.

[1] See Masten, A., et al. "Underage Drinking: A Developemental Framework." *Pediatrics* 121 (Supplement 4), 2008.

# Washington State Focuses on Underage Drinking.

The Division of Behavioral Health and Recovery (DBHR) has chosen reducing underage drinking as one of its key strategic priorities for 2009-2013. Research is increasingly indicating powerful short-term and long-term negative impacts resulting from youth drinking.

When all available data about youth substance abuse was recently analyzed to determine a statewide priority for the federal Strategic Prevention Framework-State Incentive Grant (SPF-SIG), youth alcohol use was found to have substantially more profound consequences on youth and their communities than either tobacco or marijuana use. Alcohol prevalence rates among youth are highest, trends are increasing most, economic impact is greatest, and there is the largest association with negative consequences.[1] While the negative impacts of binge drinking on the growing brains of adolescents has been recognized for some time, what is now better understood is that early initiation of alcohol use, even at relatively low levels, has harmful effects both during adolescence and when youths reach adulthood.

| Drinking Behavior | Behavior/Consequence | How much more likely are youth who drink to exhibit the problem behaviors than non-drinking youth? |
|---|---|---|
| Youth who drink 1-2 days in the past 30 days but did not get drunk | Showing up to school drunk or high | 3.2 times more likely (16% for 1-2 day drinkers vs. 5% for non-drinkers) |
| Youth who drink 3-5 days in the past 30 days but did not get drunk | Getting D's and F's in classes | 1.8 times more likely (15% for 3-5 day drinkers vs. 8% for non-drinkers) |
| Youth who drink 3-5 days in the past 30 days or had been drunk once | Seriously considered suicide | 2 times more likely (22% for 3-5 day drinkers vs. 11% for non-drinkers) |
| Youth who drink 6+ days in the past 30 days or had been drunk two or more times | Low commitment to school | 2.1 times more likely (65% for 6+ day drinkers vs. 31% for non-drinkers) |

Source: Campbell, K., & Gabriel, R., *Analysis of 2006 Washington State Healthy Youth Survey*, 2007.

The 12 communities involved with the SPF-SIG project and the four communities involved with the Reducing Underage Drinking (RUaD) projects are leading the way for the state as a whole to learn how best to reduce underage drinking. Lessons learned from the SPF-SIG and RUaD projects will be applied throughout the DASA prevention and treatment systems.



[1] *Washington State Strategic Prevention Framework State Incentive Grant (SPF-SIG) Implementation Plan, 2006.* Olympia, WA: Washington State Division of Alcohol and Substance Abuse, 2006.

# Youth Alcohol Use Has Significant Adverse Impacts on the Brains of Adolescents.

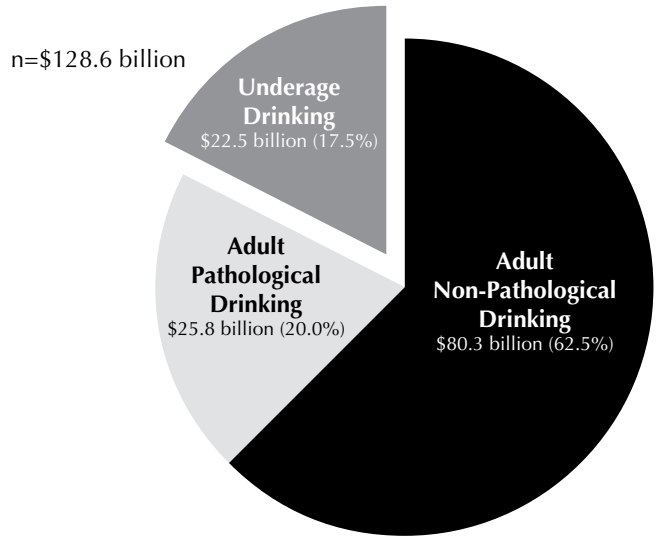
Recent scientific research has focused attention on the negative impacts of early alcohol use on the developing brains of adolescents, and on both the short- and long-term effects of this use. Specifically, studies reviewed by the American Medical Association found that early and persistent drinking may result in reduction in the size of the hippocampus, a portion of the brain heavily responsible for memory and memory-related activities by as much as 10%. In addition, alcohol use can slow prefrontal lobe development, which plays an important role in forming adult personality and behavior, affecting the ability to execute tasks such as planning, integrating information, abstract thinking, problem-solving, judgment, and reasoning. Damage from alcohol use during the teen years can be long-term and irreversible. Because adolescence is a period of dynamic growth in the brain, it may be more susceptible to damage than the adult brain.[1]

Compared with non-drinkers, research has found the following effects of alcohol use among youth drinkers:

- Adolescent drinkers scored worse on vocabulary, general information, memory, and memory retrieval.
- Verbal and nonverbal information recall was most heavily affected, with a 10% performance decrease in alcohol users.
- Significant neuropsychological deficits exist in early to middle adolescents (ages 15-16) with histories of extensive alcohol use.
- Adolescent drinkers perform worse in school, are more likely to fall behind, and have an increased risk of social problems, depression, suicidal thoughts, and violence.
- Alcohol affects the sleep cycle, resulting in impaired learning and memory as well as disrupted release of hormones necessary for growth and maturation.
- Alcohol use increases risk of stroke among drinkers.[2]

[1] Ziegler, D., et al., for the Council on Scientific Affairs, American Medical Association. "The Neurocognitive Effects of Alcohol on Adolescents and College Students." *Preventive Medicine* 40(1), 2005.
[2] American Medical Association. *Brain Damage Risks*. Chicago, IL: 2005.

# Underage Drinking Accounted for 17.5% of the Cash Value of Total U.S. Consumer Expenditures for Alcohol in 2001.

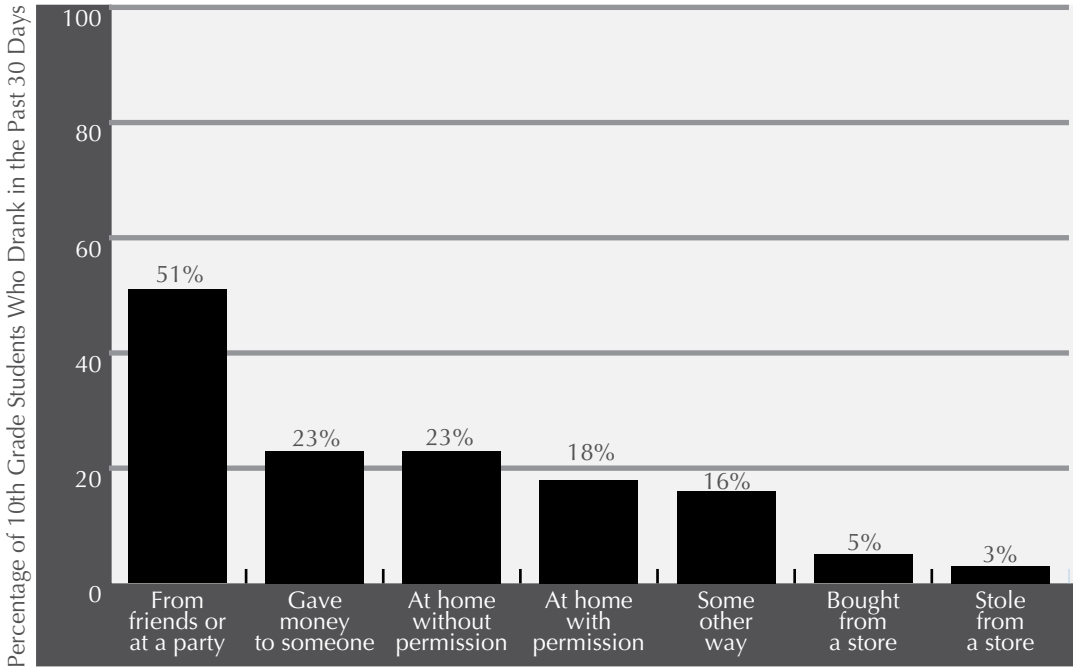



Source: Foster, S., et al., "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.

Taken together, drinking among youth ages 12-20 and pathological drinking among adults (abuse and dependence) accounts for almost 38% of total U.S. expenditures for alcohol.

# In 2008, Only 5% of Washington State 10th Graders Who Drink Usually Purchased Alcohol from a Store Themselves.

***During the past 30 days, how did you usually get alcohol (beer, wine, or hard liquor)? Choose all that apply.****



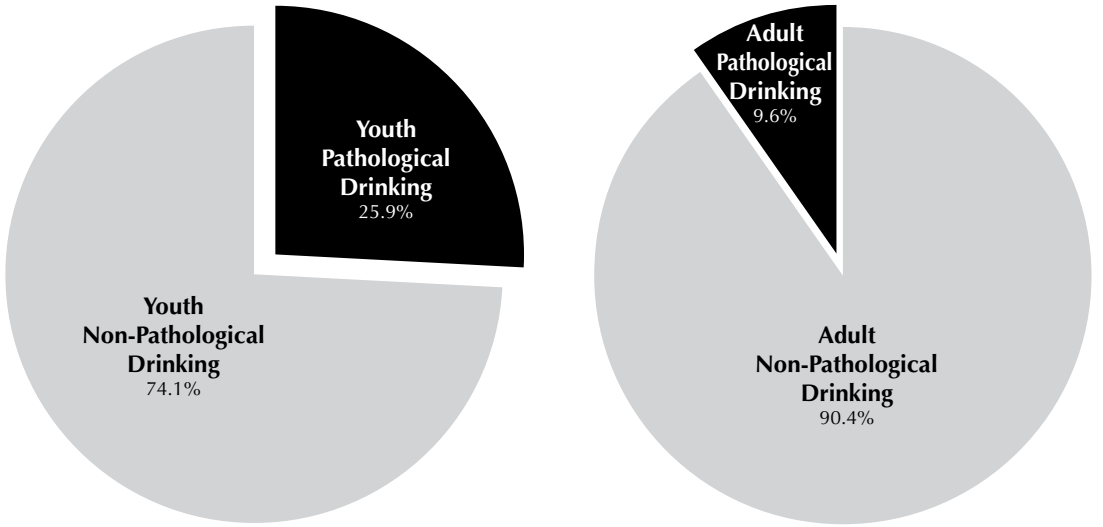

Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey – 2008*.

In Washington State, the level of compliance with alcohol sales laws prohibiting sales to individuals under age 21 is very high. Nevertheless, youth are able to obtain alcohol from social sources. Some 59% of 10th graders report that alcohol is easy to get. Most drinking is done with friends and at parties, but almost one-fifth (18%) of 10th graders who drank in the past 30 days reported obtaining alcohol at home with their parents' or guardians' permission.

**Note: These percentages vary slightly from published Healthy Youth Survey data due to the exclusion of individuals who reported no past 30-day alcohol use but who did report an alcohol source within the past 30 days.*

[1] Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey – 2008*. Olympia, WA: 2009.

# Youth Ages 12-20 Who Drink Alcohol are More than Twice as Likely to Be Pathological Drinkers than Adult Drinkers.




Source: Foster, S., et al., "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.

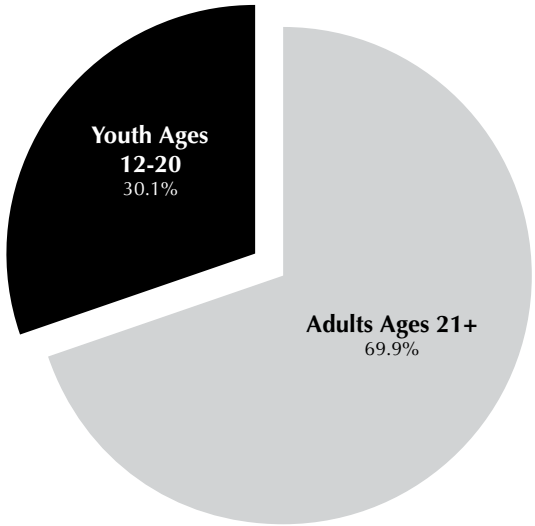
Pathological drinkers are those who meet criteria for alcohol abuse or dependence as defined by the *Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition* of the American Psychiatric Association. In 2001, the percentage of youth ages 12-20 who drank alcohol in the past 30 days (47.1%) was similar to the rate for adults (53.7%). However, the rate of youth who were alcohol dependent (12.2%) was more than twice that of adults.[1]

Some research suggests that moderate drinking among teenagers (ages 12-17) is relatively uncommon. A 2009 survey conducted for the National Center on Addiction and Substance Abuse at Columbia University (CASA) found that nearly two-thirds (65%) of teens who drank in the past month report they get drunk at least once in a typical month. This relationship is even stronger among older teens, with 85% of 17-year-olds who drank in the past moonth reporting they get drunk at least monthly.[2]



[1] Foster, S., et al. "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.
[2] National Center on Addiction and Substance Abuse at Columbia University (CASA). *National Survey of American Attitudes on Substance Abuse XIV: Teens and Parents*. New York, NY: CASA, August 2009.

# Youth Ages 12-20 Account for 30% of All U.S. Abusive and Dependent Drinkers.




**Alcohol-Abusing and Dependent Youth Ages 12-20 as a Percentage of All Abusing and Dependent Drinkers Ages 12 and Above, 2001**

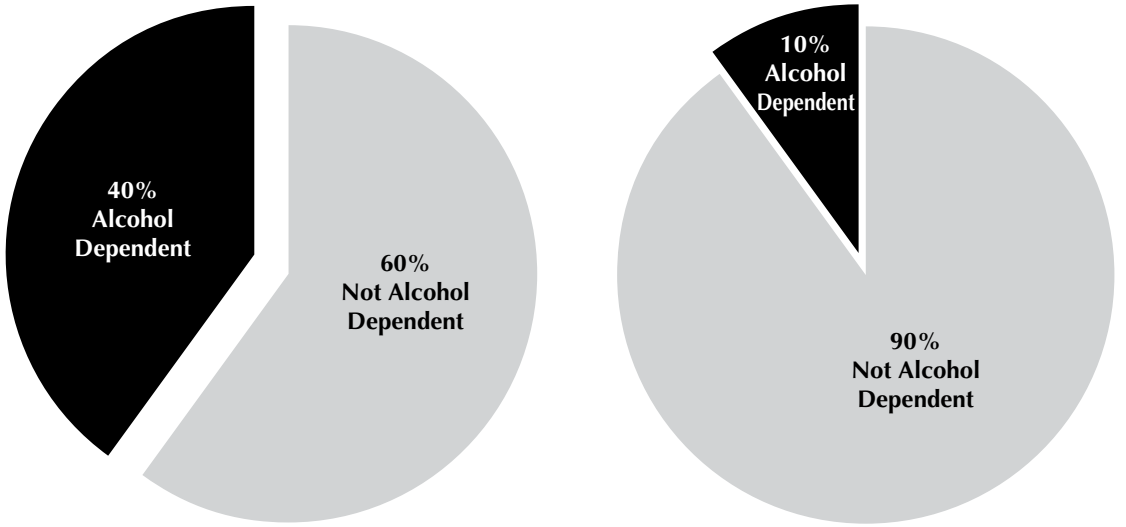
Source: Foster, S., et al., "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.

Although youth ages 12-20 represented only 15.4% of the population in 2001, they accounted for 30.1% of individuals who meet criteria for abusive or dependent drinking as defined by the *Diagnostic and Statistic Manual of Mental Disorders – Fourth Edition* published by the American Psychiatric Association.

Underage drinkers are much more likely to remain or become abusive or dependent drinkers as adults.[1] A study of twins published in 2009 found that risk of alcohol dependence symptoms increased as the age of individuals' first drink decreased. Further, genetic influences on dependence symptoms were considerably larger for those who reported a first drink prior to age 13. Early drinking may facilitate the expression of genes associated with vulnerability to future alcohol dependence.[2]

[1] Foster, S., et al. "Estimate of the Commercial Value of Underage Drinking and Adult Abusive and Dependent Drinking to the Alcohol Industry," *Archives of Pediatrics and Adolescent Medicine* 160, May 2006.
[2] Arpana, A., et al. "Evidence for an Interaction Between Age at First Drink and Genetic Influences on DSM-IV Alcohol Dependence Symptoms." *Alcoholism: Clinical and Experimental Research*, December 2009.

# Youth Who Start Drinking at Age 14 or Younger are Four Times More Likely to Become Alcohol Dependent in Their Lifetimes than Those Who Start Drinking at Age 20 or Older.




**Rate of Lifetime Alcohol Dependence for Individuals Who Begin Drinking At or Before Age 14**

**Rate of Lifetime Alcohol Dependence for Individuals Who Begin Drinking At or After Age 20**

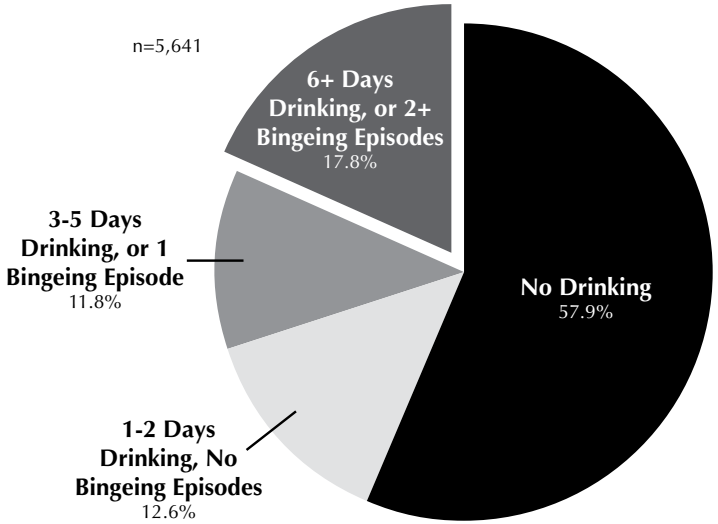
Source: Grant, B. & Dawson, D., "Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence: Results from the National Longitudinal Alcohol Epidemiology Study," *Journal of Substance Abuse* 9, 1997.

Early onset of alcohol use is an excellent predictor of future lifetime abuse and dependence. The probability of an individual becoming alcohol dependent during his/her lifetime decreases by 14% with each increasing year of age (after age 14) at onset of use. The probably for lifetime alcohol abuse decreases by 8% with each increasing year of age at onset of use.[1] This suggests that prevention strategies that aim at delaying age of onset of drinking might be effective in reducing future alcohol abuse and dependence among adults. A recent study found that youth who witness domestic violence or experience physical or sexual abuse before age 10 are significantly more likely to drink before age 13.[2] A 2009 study found that early (before age 13) drinking may facilitate the expression of genes associated with vulnerability to future alcohol dependence.[3]

[1] Grant, B. & Dawson, D. "Age at Onset of Alcohol Use and Its Association with DSM-IV Alcohol Abuse and Dependence: Results from the National Longitudinal Alcohol Epidemiology Study," *Journal of Substance Abuse* 9, 1997.
[2] Hamburger, M., et al. "Childhood Maltreatment and Early Alcohol Use Among High-Risk Adolescents." *Journal of Studies of Alcohol and Drugs* 69, 2008.
[3] Arpana, A., et al. "Evidence for an Interaction Between Age at First Drink and Genetic Influences on DSM-IV Alcohol Dependence Symptoms." *Alcoholism: Clinical and Experimental Research*, December 2009.

# By 12th Grade, Almost One Out of Five Washington State Students is Already a Problem Drinker.

***Drinking by Washington State 12th Graders in Past 30 Days, 2008***




Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey - 2009*.

In 12th grade, 17.8% of Washington State students are already problem drinkers, with six or more days of drinking during the past 30 days or two binge drinking episodes in the previous two weeks. Early drinking and high school problem drinking set the stage for more serious alcohol abuse and dependence for adolescents and adults, as well as a large range of neurocognitive effects.[1]

[1] Zeigler, D., et al. for the Council on Scientific Affairs, American Medical Association. "The Neurocognitive Effects of Alcohol on Adolescents and College Students." *Preventive Medicine* 40(1), 2005.

# Evidence-Based Strategies Can Reduce Underage Drinking.

The science of prevention has shown there are proven strategies for reducing underage drinking. These strategies fall into two broad categories:

- Environmental strategies seek to influence all the youth in a community by reducing the availability of alcohol for minors, and by changing community permissiveness for youth drinking. The first approach is usually to increase enforcement of and penalties for violation of laws related to the legal drinking age, as well as challenging norms condoning underage drinking and restricting marketing and promotion of alcohol to minors.

- Behavioral or individual-level strategies are aimed at knowledge, attitudes, and skills that help youth to resist influences that support alcohol. These strategies are usually delivered in small group settings, often in schools, and sometimes with groups that include family members.

## *Environmental Strategies*

The most widely studied strategies for impacting alcohol use among the general population focus on law enforcement and training of people who serve alcohol. Indirectly these strategies may have an effect on youth by changing the cultural norms associated with alcohol use. More direct strategies aim at underage drinking laws, "social availability" (obtaining alcohol from family, friends, etc.), and advertising and other types of promotion.

### *Availability*

According to an abundance of survey data, including the Washington State Healthy Youth Survey, few youth obtain alcohol by purchasing it from stores. They get it at parties, from friends, and from family. Decreasing this "social availability" is thus critical to reducing underage drinking. Intervention research related to social availability is in its infancy, but Washington is among many states focusing on this issue now with two federal grants, the Strategic Prevention Framework-State Incentive Grant (SPF-SIG), and the Reducing Underage Drinking (RUaD) Grant.

The State Liquor Control Board (LCB) has agents across the state who regularly conduct compliance checks in stores and bars. Communities that receive RUaD grants often add additional compliance checks by working with local police departments. The LCB also provides training for restaurant and bar servers to make sure they understand the laws and penalties, and know how to check age documentation.

There is a large body of research showing that higher alcohol prices are associated both with less alcohol consumption and fewer associated problems. While most youth do not buy alcohol from retail sources, some researchers have calculated that increasing the cost of alcohol commensurate with inflation would yield a 19% reduction in heavy drinking among today's youth.[2] Besides the direct impact on kids who give money to others who buy alcohol for them, higher prices for young adults may reduce their willingness to share their alcohol with youth.

***Advertising***

The authors of *Reducing Underage Drinking: A Collective Responsibility* argue that there are compelling reasons to reduce youth exposure to alcohol advertising[3], and there is increasing evidence to support this. A 2008 study found that receptivity to alcohol marketing predicts initiation of alcohol use.[4] While television (both advertising and program content) and song lyrics get much attention from parents and community groups, seemingly mundane advertising on storefronts also exposes youth to positive images of drinking. One study published in 2007, for example, found that higher exposure of 6th graders to outdoor advertising near their schools was associated with increased intentions to use alcohol at the end of 8th grade.[5] The authors of this study demonstrate that, given the repetitive, daily exposure of children and young adolescents to advertising near their schools, it is particularly critical that the density of alcohol advertising around schools be subject to public discourse. In 2009, the Washington State Liquor Control Board adopted new rules limiting the scope of alcohol promotion and the placement of alcohol advertising.

The 2007 U.S. Surgeon General's Call to Action suggests that alcohol companies have a public responsibility to ensure that the placement of their advertising does not disproportionately expose youth to messages about alcohol.[6] In 2003, the alcohol industry adopted voluntary restrictions on their advertising, promising to limit ads where youth make up more than 30% of the audience. However, a 2007 study released by the Center on Alcohol Marketing and Youth indicates that more than a third of alcohol radio ads placed in 2006 were more likely to be heard by underage youth than adults.[7]

***Laws***

Public policies, laws, and regulations all affect the availability of alcohol and can limit the promotion of alcohol. However, their potential for affecting alcohol use strongly depends upon their consistent and effective enforcement within the justice system. The evidence indicates that as the actual and/or perceived likelihood of being detected and arrested or cited for law violations increases, so does compliance.

A list of policies or regulations in Washington State include:

- Taxation, which increases the price of alcohol.
- The minimum legal drinking age 21.
- .08 blood alcohol content (BAC) for drinking-and-driving violations.
- Zero tolerance for underage divers.
- Graduated drivers' licensing.
- Alcohol advertising rules.

These prevention efforts focus on the formal laws and regulations related to alcohol use. However, social and cultural norms and values around drinking affect the acceptability or unacceptability of the behavior. Youth living in environments in which drinking and/or excessive drinking is not the norm tend to drink less. Research suggests that community norms that result in stronger laws and better enforcement of existing laws are the most effective deterrent to alcohol use among youth.

## *Behavioral Strategies*

There are many well-researched prevention programs that reduce risk factors and enhance protective factors for alcohol use. The most widely used are universal strategies – that is, they are appropriate for the entire youth population who might use alcohol.

### *School-Based Programs*

School is a setting in which most youth can be easily reached, and there is usually a place in the school curricula for alcohol to be addressed. Addressing alcohol use is consistent with the broader goals of education. Research on school-based prevention efforts indicate that programs that rely on information alone, fear tactics, or messages about not drinking until one is "old enough" are ineffective in reducing alcohol use.[8] They may increase knowledge, but they do not affect behavior positively.

One evidence-based program sponsored by the Division of Alcohol and Substance Abuse is called All Stars. The goal of this program is to support non-drinking norms among students by demonstrating that substance use among their peers is not as high as they might think, and that it is generally not approved of by their peer group. Research indicates that eleventh graders who participated in the program in fifth grade had lower levels of alcohol and tobacco use than their peers who did not participate in the program.[9]

The LifeSkills Training program is a broader personal and social skills training curricula for middle school children, and is designed to prevent tobacco, alcohol, and marijuana use. With 10 published evaluations, LifeSkills has shown demonstrated reductions in substance use of up to 50-75% at the seventh-grade follow-up.[10] A recent six-year follow-up of 4,466 students who were enrolled in the program in 7th grade indicates that results erode only slightly by the end of high school, with a 66% reduction in substance use.[11]

### *Family-Based Programs*

Parents are the primary influence in their children's decisions about drinking.[12] Family-based prevention programs encourage parents to set and consistently enforce clear rules about drinking, and to monitor their children's activities. There is often also an emphasis on family management practices and communication skills.

One universal program widely implemented in Washington is the Strengthening Families Program (SFP) for parents with children who are 10-14. SFP helps to improve family communication strategies that aid children in avoiding the risks commonly faced by adolescents. While not focused specifically on alcohol use, researchers have found in follow-up studies that children whose families participate in SFP while their children are 10-14 have reduced alcohol use when they are 16.[13] SFP also changes the environment of schools in which the program is offered, because even students whose families do not participate benefited from the program.[14]

Some family-based prevention projects have an alcohol-specific focus. Guiding Good Choices (formerly called Preparing for the Drug-Free Years) was developed at the University of Washington and is meant for families with children 8 to 14. This program empowers parents with the skills needed to enhance protective factors (i.e., improving bonding by increasing opportunities for involvement and interaction) and reduce risk factors with training on effective family management techniques and instruction on reducing family conflict.[15]

## *Prevention, Early Intervention, and Treatment for High-Risk Children*

Children in families with histories of alcohol dependence are at higher risk for alcohol problems themselves. Targeted strategies to reduce parental and sibling alcohol dependence, as well as improve family management, have been shown to be effective in reducing this risk. Many programs also improve bonding between family members, which an important part of the protective factor process. One well-researched program for children whose parents are substance abusers, and that has been implemented in Washington State, is the original Strengthening Families program.[16]

Analysis of the Washington State Healthy Youth Survey indicates that the best predictor of heavy drinking among youth is the risk factor, "friends who use". Prevention programs include components to help youth resist peer pressure and to make better choices about their friends. It is likely that intervening and, when needed, providing treatment for heavy drinkers among youth could have a ripple effect among peers. The high percentage of heavy drinkers among youth combined with the relatively low number of youth in treatment for primary alcohol problems indicates that relatively few youth with drinking problems receive treatment. Current services may not be optimally designed for this population. Youth prefer easy-access, low-threshold approaches that accentuate strategies adolescents normally use to stop drinking[17], and treatments that do not remove them from their primary home or academic settings.[18] Brief intervention tailored to salient adolescent concerns may be the desired approach.[19] There are currently 254 preventive interventionists in 192 Washington school districts, providing an array of counseling, peer support groups, social skills training, and individual and family interventions, as well as referral to treatment when appropriate.

[1] Chaloupka, F. "The Effects of Price on Alcohol Use, Abuse, and Their Consequences," in *Reducing Underage Drinking: A Collective Responsibility*, Bonnie, R., & O'Connell, M., eds., National Research Council and Institute of Medicine. Washington, DC: The National Academies Press, 2004; Wagenaar, A., et al. "Effects of Beverage Alcohol Price and Tax Levels on Drinking: A Meta-Analysis of 1003 Estimates from 112 Studies." *Addiction* 104(2), 2009.
[2] Laixuthai,A., & Chaloupka, F. "Youth Alcohol Use and Public Policy." *Contemporary Policy Issues* 11(4), 1993.
[3] *Reducing Underage Drinking: A Collective Responsibility*, op. cit..
[4] Pasch, K. , et al. "Outdoor Alcohol Advertising Near Schools: What Does It Advertise and How Is It Related to Intentions and Use of Alcohol Among Young Adolescents?" *Journal of Studies on Alcohol and Drugs* 68:587-596, 2007.
[5] U.S. Department of Health and Human Services. *The Surgeon General's Call to Action To Prevent and Reduce Underage Drinking.* Rockville, MD: Department of Health and Human Services, Office of the Surgeon General, 2007.
[6] CAMY Monitoring Report: Youth Exposure to Alcohol Advertising on Radio 2006. Washington, DC: The Center on Alcohol Marketing and Youth, Georgetown University, September 2007.
[7] Ibid.
[8] Taylor, B., et al. "Modeling Prevention Program Effects on Growth in Substance Use: Analysis of Five Years of Data from the Adolescent Alcohol Prevention Trial." *Prevention Science* 1(4), 2000.
[9] Botvin, G., et al. "Preventing Tobacco and Alcohol Use Among Elementary School Students Through Life Skills Training," *Journal of Child & Adolescent Substance Abuse* 12(4), 2003.
[10] Botvin, G., et al. "Long-term Follow-up Results of a Randomized Drug Abuse Prevention Trial in a White Middle-class Population." *Journal of the American Medical Association* 273(14), 1995.
[11] Barnes, G., et al. "The Effects of Parenting on the Development of Adolescent Alcohol Misuse: A Six-Wave Latent Growth Model." *Journal of Marriage and Family* 62, 2000.
[12] Spoth, R., Redmond, C., and Shin, C. "Randomized Trial of Brief Family Interventions for General Populations: Adolescent Substance Use Outcomes 4 Years Following Baseline." *Journal of Consulting and Clinical Psychology* 69, 2001.
[13] Spoth, R., et al. "Brief Family Intervention Effects on Adolescent Initiation: School-level Growth Curve Analysis 6 Years Following Baseline." *Journal of Consulting and Clinical Psychology* 72, 2004; Wagenaar, A., et al. "Effects of Beverage Alcohol Price and Tax Levels on Drinking: A Meta-Analysis of 1003 Estimates from 112 Studies." *Addiction* 104(2), 2009
[14] Park, J., et al. "Effects of the "Preparing for the Drug Free Years" Curriculum on Growth in Alcohol Use and Risk for Alcohol Use in Early Adolescence." *Prevention Science* 1(3), 2000.
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# Washington State Responds to Underage Drinking

Washington State administers two large federal grants focusing on underage drinking, implementing strategies both statewide and in grantee communities.

## *Reducing Underage Drinking (RUaD) - Statewide Efforts*

The Division of Behavioral Health and Recovery (DBHR) has been the recipient of the federal Office of Juvenile Justice and Delinquency Program's (OJJDP) Enforcing Underage Drinking Laws grants since 1998. In Washington State, these efforts are known as Reducing Underage Drinking (RUaD).

Key leaders representing 24 state agencies and statewide organizations meet monthly to provide collaborative leadership on reducing underage alcohol use in Washington State. The purpose of the Washington State Coalition to Reduce Underage Drinking (RUaD Coalition) is to:

- Increase public awareness about the harmful effects of underage drinking.
- Serve as a communication hub for underage drinking issues.
- Provide guidance that may impact public policy.
- Collect information and concerns from local communities.
- Provide an advisory body for the OJJDP-funded Reducing Underage Drinking programs and support the Strategic Prevention Framework-State Incentive Grant (SPF-SIG) Advisory Council and other underage drinking-related initiatives, where appropriate.
- Review, track, and disseminate relevant data.
- Provide opportunities to share information and coordinate efforts among state agencies, tribes, statewide organizations, and others.

Beginning in 2007, the RUaD Coalition has conducted annual social marketing campaigns targeting parents. The messages (television, radio, newspaper, billboard, direct mail) are designed to get parents and other influential adults past awareness and into action. A website www.starttalkingnow.org was developed to assist. The most recent campaign reached an estimated 3.5 million people. An evaluation of the 2009 campaign indicated that:

- On average, 22% of parents surveyed remembered hearing ads.
- Parents who said they talked with and monitored their children increased by 8%.
- Twice as many parents thought underage drinking is a problem.

A video project - *Underage Drinking in Washington: Something to Talk About* - paid for by the federal Substance Abuse and Mental Health Services Administration developed collaboratively by the RUaD Coalition's Communication Impact Team, was completed in August 2009. The eight-minute DVD will be distributed widely through RUaD partnerships to schools, county and tribal prevention specialists, local public health departments and districts, and others, and is also available on the Start Talking Now website.

## *RUaD Community-Based Efforts*

RUaD's Rural Community Initiative ended in September 2009. Four communities completed extensive three- to four-year plans including coalition-driven enforcement and policy work. A national evaluation of this seven-state OJJDP-funded project is underway.

A "reduced marketing to youth" mini-grant project gave six coalitions an opportunity to pilot-test the *Action Kit: Reducing Alcohol Marketing to Youth*. Improvements and additions to that tool are under development based on their experiences and input from more than 30 other local prevention coordinators who had access to the kit.

## *Strategic Prevention Framework-State Incentive Grant (SPF-SIG)*

The SPF-SIG is a five-year grant funded by the Center for Substance Abuse Prevention. The primary focus of the grant program is to demonstrate the implementation of the five-step planning process known as the Strategic Prevention Framework. In Washington State, this framework is being employed in 12 communities to target underage drinking. These communities were selected randomly from a large group of schools that had high rates of eighth grade alcohol use. Each will receive more than $600,000 over five years to develop the ability to sustain the SPF process, and to implement their strategic plans to reduce underage drinking.

The 12 sites are based in middle schools in:

- Asotin, Asotin County
- Burlington, Skagit County
- Franklin Pierce School District, Pierce County
- Kelso, Cowlitz County
- Naches, Yakima County
- Port Angeles, Clallam County
- Port Gamble S'Klallam Tribe (tribe rather than middle school-based), Kitsap County

- Seattle (two sites), King County
- Warden, Grant County
- Wenatchee, Chelan County
- White Swan, Yakima County

***Statewide Goals***

Statewide, the goals of SPF-SIG are broader:

- Prevent the onset and reduce the progression of underage drinking.
- Reduce substance abuse-related problems in grantee communities.
- Build prevention capacity and infrastructure at the state and community levels to support implementation of the SPF process.
- Infuse data-based decision-making across all steps of the SPF process.

***Evaluation Strategy***

In an ambitious plan promoted by the SPF-SIG Advisory Council, the design of the evaluation breaks new ground in the field of prevention. Using Healthy Youth Survey data, the project identified all the schools in the state that had high eighth grade alcohol use. Forty-seven of these schools passed the readiness eligibility requirement and submitted applications. From these, ten communities were randomly drawn to receive funds, with the others to act as comparison sites. In addition, two Native American communities were selected to receive grant funding.

Two basic evaluation questions frame the approach to the outcome evaluation:

1. Are communities that implement Strategic Prevention Framework more successful at reducing underage drinking and related problems than those that do not?
2. What characteristics of SPF-SIG communities and their prevention efforts are associated with greater success in reducing underage drinking and related problems?

***State Epidemiology Workgroup***

In order to promote data-based decision-making, the federal Center for Substance Abuse Prevention requires that each SPF-SIG state maintain a State Epidemiology Workgroup (SEW). Washington State has been in the forefront of states collecting statewide needs assessment data. Therefore the SEW is able to refine their mandate to include: (a) study of health-related disparities among subpopulations of state residents; (b) coverage of its survey data collection systems to include older age groups and out-of-school youth; and (c) enhanced availability of data from other state systems at subcounty geographic levels.

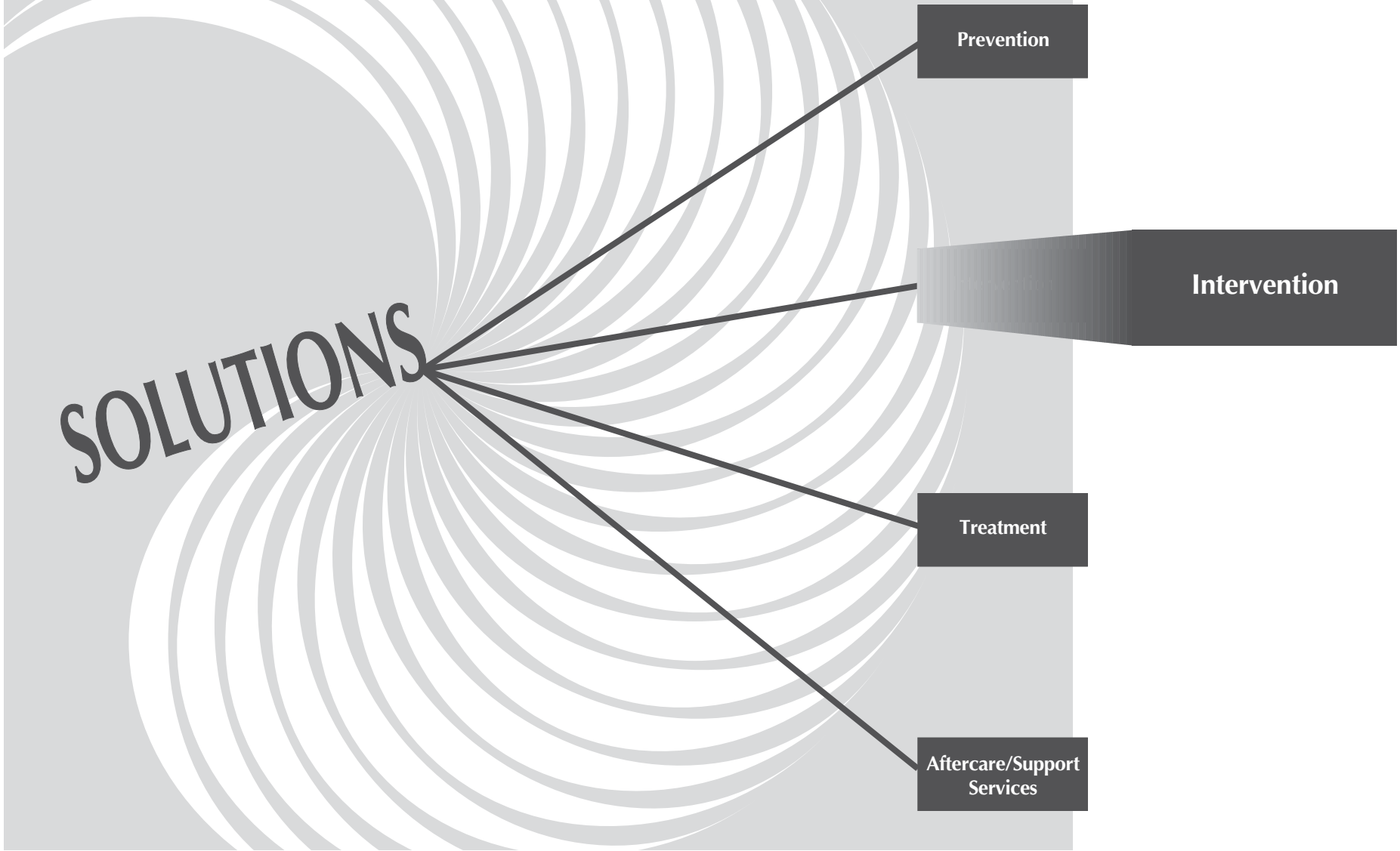
# State Prevention Framework-State Incentive Grant (SIG)

## *Prioritized Environmental Influences and Risk/Protective Factors in SPF-SIG Communities*

Based on an analysis of community data, the SPF-SIG communities selected a range of environmental influences and risk and protective factors to receive prioritized focus in the development of programming to prevent underage drinking.

| | Asotin | Burlington | Eckstein | Huntington | Madison | Morris Ford | Mt. Adams | Naches Valley | Orchard | Port Gamble | Roosevelt/Port Angeles | Warden |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **ENVIRONMENTAL INFLUENCES** | | | | | | | | | | | | |
| Social Access to Alcohol | | | | | | ■ | | ■ | ■ | ■ | ■ | ■ |
| Enforcement of Underage Drinking Laws | ■ | | ■ | ■ | ■ | | ■ | | | | ■ | ■ |
| Promotion of Alcohol | | ■ | | | | | | | | | | |
| **PSYCHOSOCIAL RISK FACTORS** | | | | | | | | | | | | |
| Early Initiation of Drug Use | ■ | ■ | | ■ | ■ | ■ | | | ■ | ■ | | ■ |
| Community Laws & Norms Favorable to Drug Use | ■ | | | | ■ | ■ | ■ | ■ | ■ | ■ | | |
| Perceived Risk of Drug Use | | | | | | | | | ■ | | | |
| Poor Family Management | | ■ | ■ | | ■ | | | | | | ■ | ■ |
| Parental Attitudes Favorable to Drug Use | ■ | | | | | | ■ | | | | | |
| Friends' Use of Drugs | | | | | | | | ■ | | ■ | ■ | |
| (Youth) Favorable Attitudes Towards Drug Use | | | ■ | | | | | | | | | |
| Parental Attitudes Favorable to Antisocial Behavior | | | | | | ■ | | | | | | |
| Intentions to Use | | | ■ | | | | | | ■ | | | |
| Early Initiation of Antisocial Behavior | | | | ■ | | | | | | | | |
| **PSYCHOSOCIAL PROTECTIVE FACTORS** | | | | | | | | | | | | |
| Belief in the Moral Order | | | | ■ | | | | | | | ■ | |
| Interaction with Prosocial Peers | | | | | | | | | | | ■ | |

# Solutions: Substance Abuse Prevention, Intervention, Treatment, & Aftercare/Support Services



# Intervention Services

Traditionally the Division of Alcohol and Substance Abuse (DASA – now the Division of Behavioral Health and Recovery, DBHR) has been thought of as the state agency funding substance abuse prevention and treatment services. The reality is that there is an array of substance abuse-related services delivered across a continuum of need. The "PITA" continuum – Prevention, Intervention, Treatment, and Aftercare/Support – is designed to improve the health of Washington residents and their families by providing the appropriate service in a timely manner depending on the level of need.

Intervention services are aimed at reducing the risk of harm to individuals before substance abuse has developed into chemical dependency. Additionally, such services may be aimed at those who, whether chemically dependent or not, initially seek to decrease problem behaviors before they are prepared to be wholly abstinent from alcohol or other drugs.

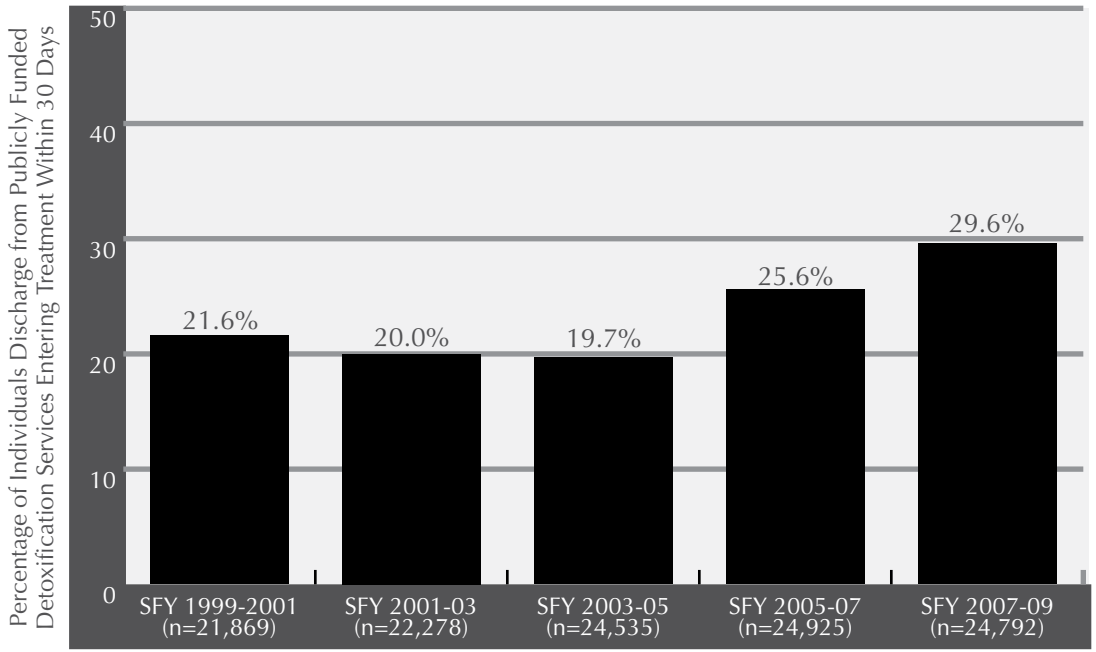
Examples of intervention services include:

- School-based intervention services.
- Alcohol and drug information school for individuals convicted of driving-under-the-influence (DUI), but who are not assessed as having significant alcohol/drug problems.
- Counseling services provided to college students to help them reduce their drinking.
- Helpline services.
- Brief interventions in hospital emergency departments, physicians' offices, and clinics.
- Detoxification services, including referral to further treatment.
- Drug courts, family therapeutic courts, and DUI courts.

As DBHR services become more fully integrated into the delivery of other health services, interventions are likely to become a more critical part of the continuum.

## NEW/CHANGING TREND

# There Has Been a Significant Increase in the Percentage of Individuals Entering Treatment Within 30 Days of Discharge from Detoxification Services.




Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

Detoxification services present a significant opportunity for intervention at a critical stage of an individual's substance abuse trajectory. While not considered treatment by itself, detoxification provides a safe and secure, often medically supervised environment for individuals to withdraw from the acute physiological effects of substance abuse. It also affords an opportunity for chemically dependent individuals to be referred for an assessment and, from there, to treatment. In addition, publicly funded detoxification services are utilized by those who are already scheduled for treatment, but need to withdraw from the toxic effects of alcohol or other drug use before treatment entry.

The percentage of individuals who were discharged from publicly funded detoxification services and subsequently entered publicly funded treatment within 30 days has increased by 37% since the 1999-2001 Biennium. Much of this increase is likely associated with the growth in treatment opportunities first made possible through Treatment Expansion funding in the 2005-2007 Biennium.

# Washington State Screening, Brief Intervention, Referral, and Treatment (WASBIRT) Project

In the fall of 2003, the Washington State Governor's Office was awarded funding from the U.S. Department of Health and Human Services, Center for Substance Abuse Treatment (CSAT) for a five-year cooperative agreement, titled the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project. The Governor's Office directed the Division of Alcohol and Substance Abuse (DASA) to implement WASBIRT in large hospital emergency departments (EDs) across the state.

WASBIRT was designed to achieve the following goals:

- Maximize the number of ED patients with substance abuse problems who can be identified through screening.
- Deliver brief counseling - "brief intervention" - to patients who screen positive for substance use disorders.
- Deliver brief outpatient therapy through certified treatment organizations.
- Increase referrals of chemically dependent individuals to chemical dependency treatment agencies.
- Reduce subsequent emergency department use rates, medical costs, criminal behavior, disability, and death for patients with alcohol and/or other drug problems of all severity levels.
- Examine the degree to which substance abuse services can be expanded to include early intervention.
- Improve links between the medical and chemical dependency treatment communities so that providing screenings and interventions for substance use disorders can be sustained over time.

As a result of this grant, chemical dependency professionals (CDPs) provided substance use screenings, brief interventions, and referrals in nine hospitals in Clark, King, Pierce, Snohomish, Thurston, and Yakima Counties. Although federal grant funding for WASBIRT ended on January 31, 2009, the success of WASBIRT has led to sustainability and diffusion activities that will allow these services in King, Clark, Snohomish, Pierce, and Thurston Counties to continue without federal funding.

Of the 106,464 patients who received services through WASBIRT between April 2004 and January 2009, 50,581 (48%) were screened but required no additional action; 48,470 (46%) received both a screening and brief intervention; and 7,413 (7%) were also provided with brief therapy or traditional chemical dependency treatment.

# About the Washington State Screening, Brief Intervention, Referral, and Treatment (WASBIRT) Program

WASBIRT utilized a public health model to identify, intervene in, and treat substance use problems before they rise to the level of substance dependence, as well as providing direct referral to traditional chemical dependency (CD) services for those who need it. WASBIRT provided a continuum of services for patients at various levels of involvement with substance use. Successful outcomes included: reduction in substance use to safe levels; self-imposed abstinence from substances; involvement in brief therapy with a corresponding change in risk behaviors (including but not limited to total abstinence); and engagement in higher levels of traditional CD services.

## *Screening*

Screening at participating hospital emergency departments was universal; patients are not pre-identified as "substance users" prior to screening. All patients who are 18 years of age or older, not in police custody, or who are able to consent to the process (conscious and not in extreme trauma or pain, psychotic, or intoxicated) were candidates for screening. The screening, designed to identify individuals who have an alcohol and/or other drug use problem or were at risk for developing one, took from 3-5 minutes to complete.

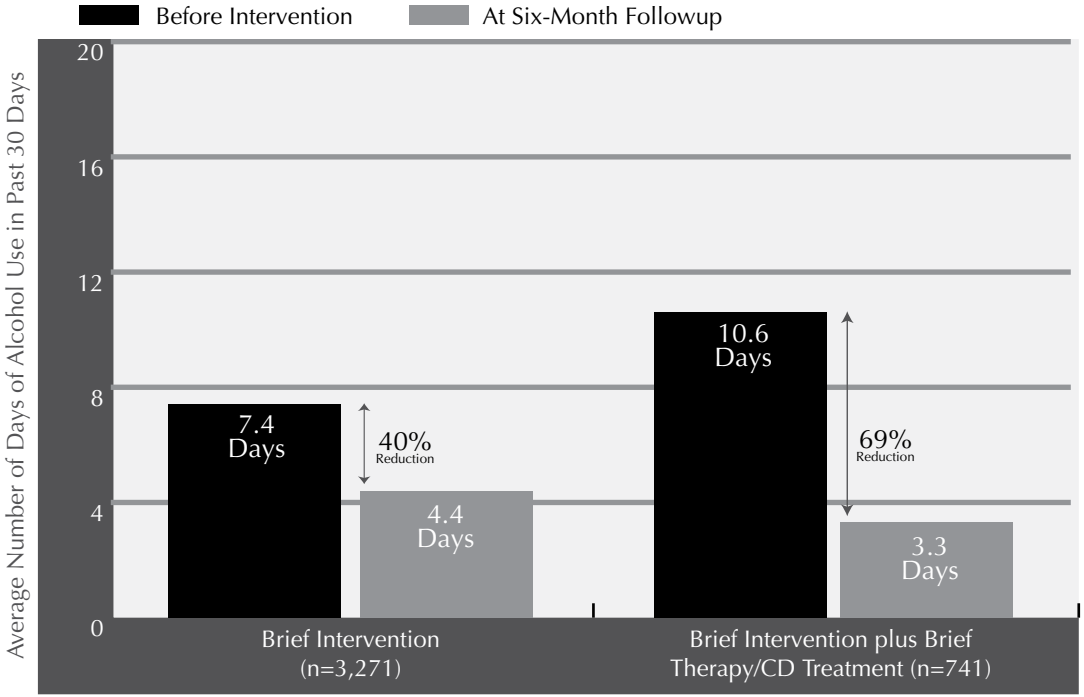
## *Brief Intervention*

Once candidates were identified and risk was assessed through the screening process, patients may have received a brief intervention (BI) in the emergency department. BI is an individual, evidence-based, protocol-driven counseling process in which concerns about an individual's substance use behavior are expressed and strategies for behavioral change are explored. BI may also be oriented toward increasing a patient's motivation to engage in higher levels of care, either in the form of brief therapy (BT), or referral to traditional CD services. Each WASBIRT BI took from 5-15 minutes, and is based on motivational interviewing techniques.

## *Brief Therapy*

Brief therapy (BT) is a focused application of therapeutic techniques specifically targeting a substance use symptom or behavior and oriented toward a limited length of treatment. As with BI, reducing the risk of psycho-social or health-related problems attributable to alcohol and/or other drug use (including but not limited to total abstinence) is the primary goal of BT. BT can be delivered either within the hospital or in a traditional CD setting. Following BT, patients may be referred to traditional CD services if further treatment is warranted.

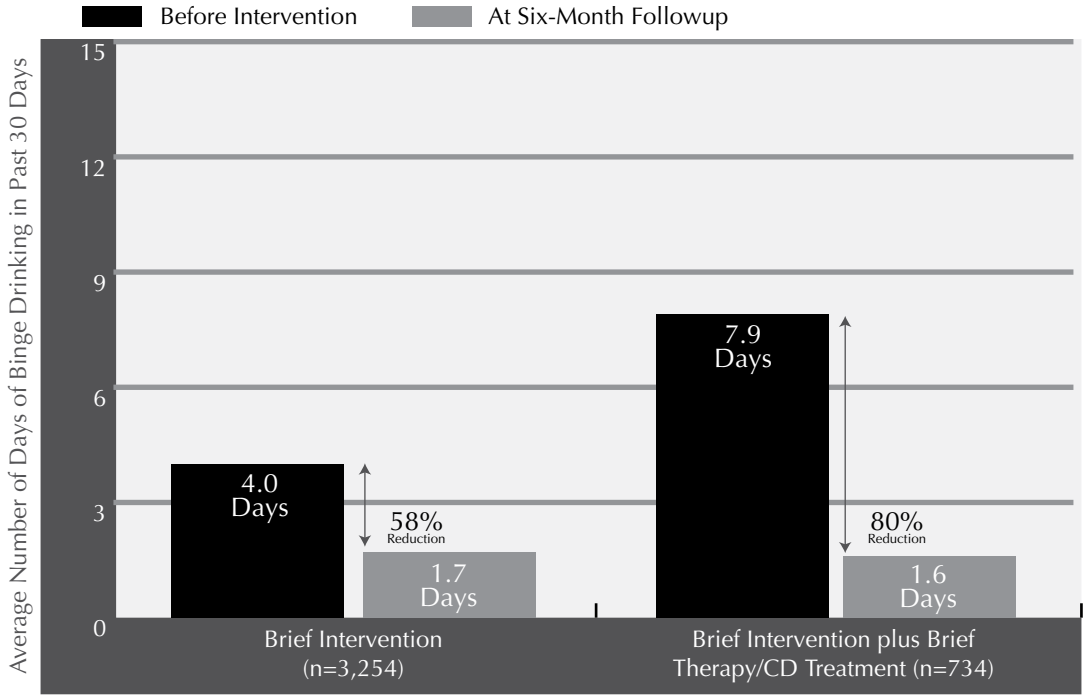
# Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Showed Up in Emergency Departments Resulted in Substantial Declines in Average Number of Days of Alcohol Use.




Source: Estee, S., et al., *Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Substance Use Outcomes* - Final Report 4.60.WA.2009.2. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2009.

At the six-month followup, average number of days of alcohol use in the past 30 days declined significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Days of alcohol use dropped 40% among those who received a brief intervention only, and 69% among those who additionally received brief therapy and/or chemical dependency treatment.

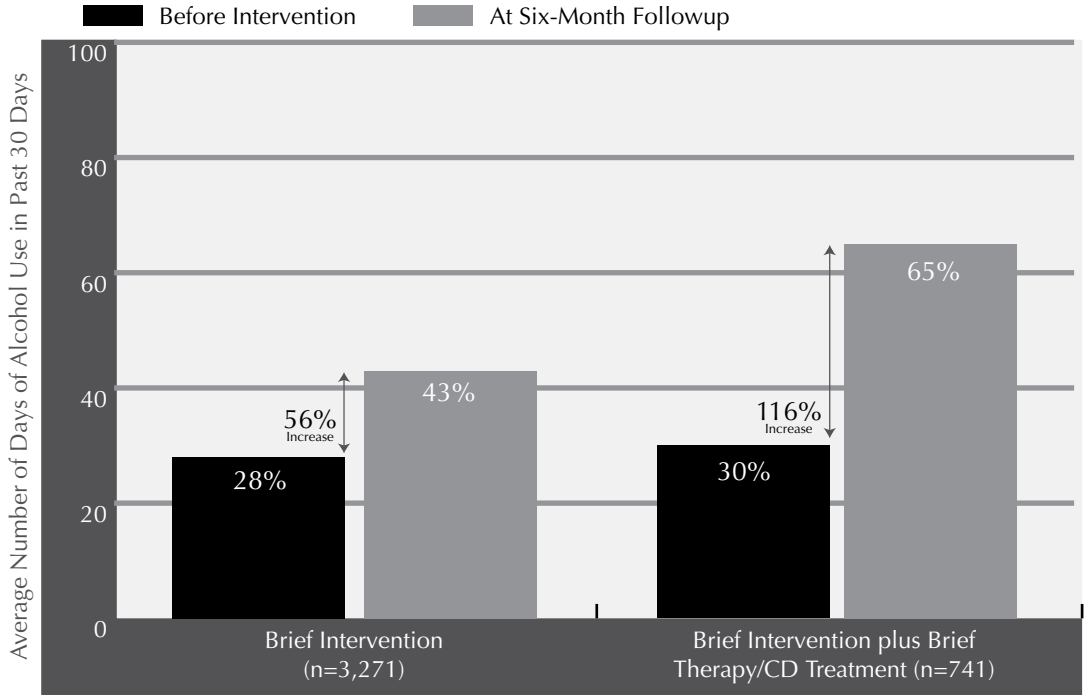
# Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Showed Up in Emergency Departments Resulted in Substantial Declines in Average Number of Days of Binge Drinking.




Source: Estee, S., He, L. et al., *Washington State Screening, Brief Intervention Referral and Treatment (WASBIRT) Substance Use Outcomes – Final Report 4.60.WA.2009.2*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2009.

At the six-month followup, average number of days of binge drinking in the past 30 days declined significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Binge drinking days decreased by 58% among those who received a brief intervention only, and 80% among those who additionally received brief therapy and/or chemical dependency treatment.

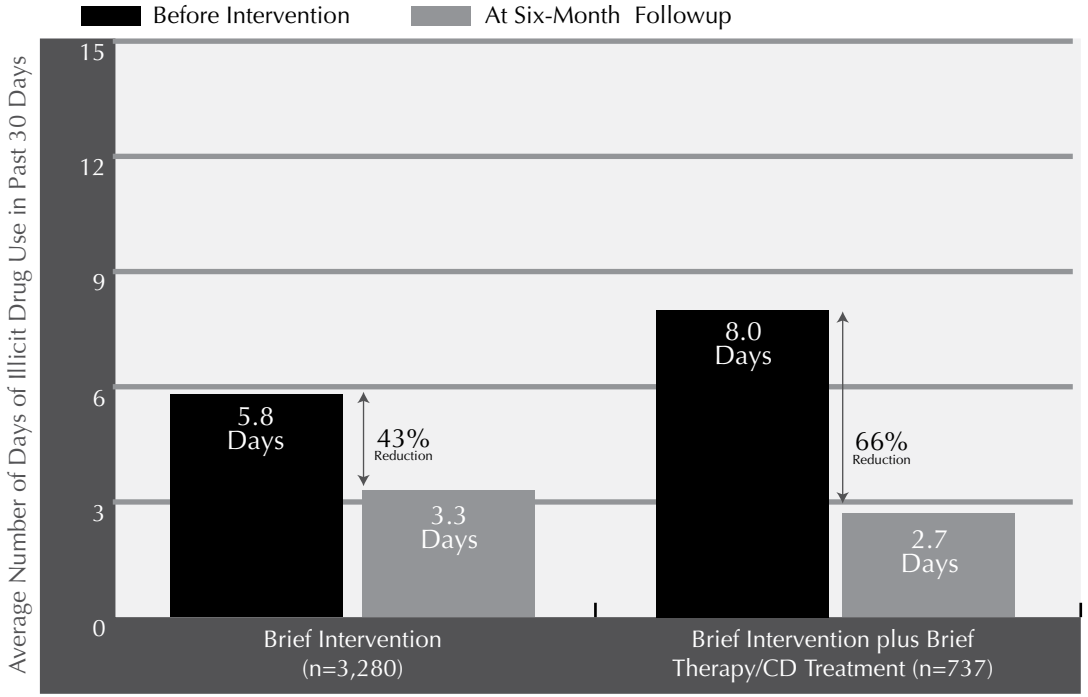
# Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Showed Up in Emergency Departments Resulted in Significant Increases in Abstinence from Alcohol Use.




Source: Estee, S., et al., *Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Substance Use Outcomes* - Final Report 4.60.WA.2009.2. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2009.

At the six-month followup, the percentage of those abstaining from alcohol use in the past 30 days increased significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Abstinence increased by 56% among those who received a brief intervention only, and 116% among those who additionally received brief therapy and/or chemical dependency treatment.

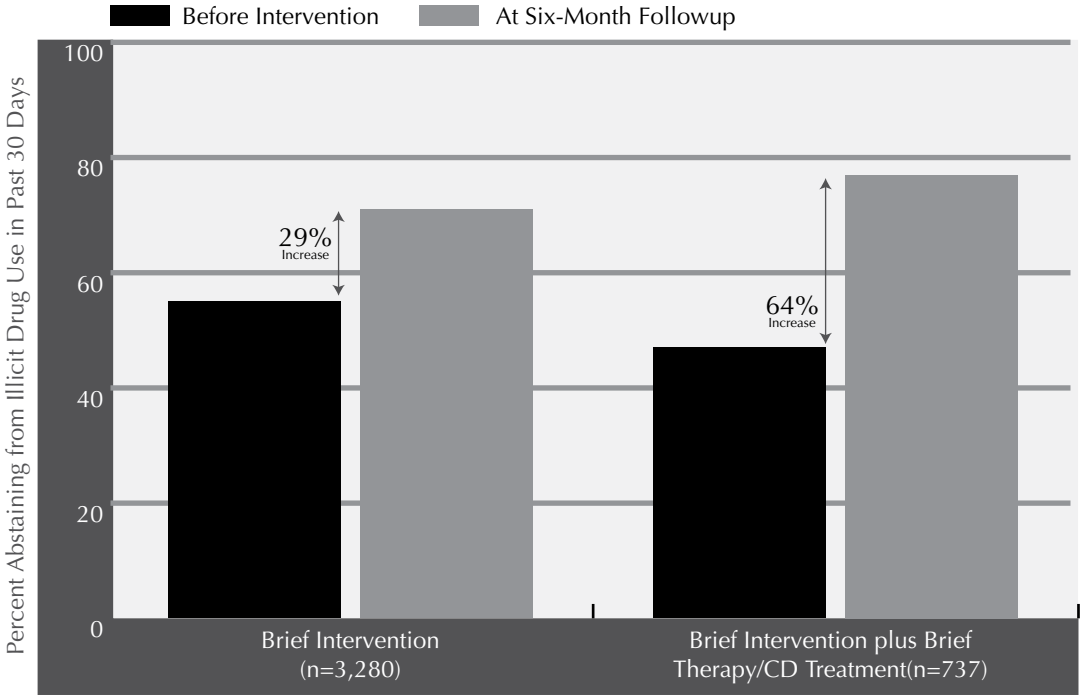
# Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Showed Up in Emergency Departments Resulted in Substantial Declines in Average Number of Days of Illicit Drug Use.




Source: Estee, S., et al., *Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Substance Use Outcomes* - Final Report 4.60.WA.2009.2. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2009.

At the six-month followup, average number of days of illicit drug use in the past 30 days declined significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Days of illicit drug use decreased by 43% among those who received a brief intervention only, and 66% among those who additionally received brief therapy and/or chemical dependency treatment.

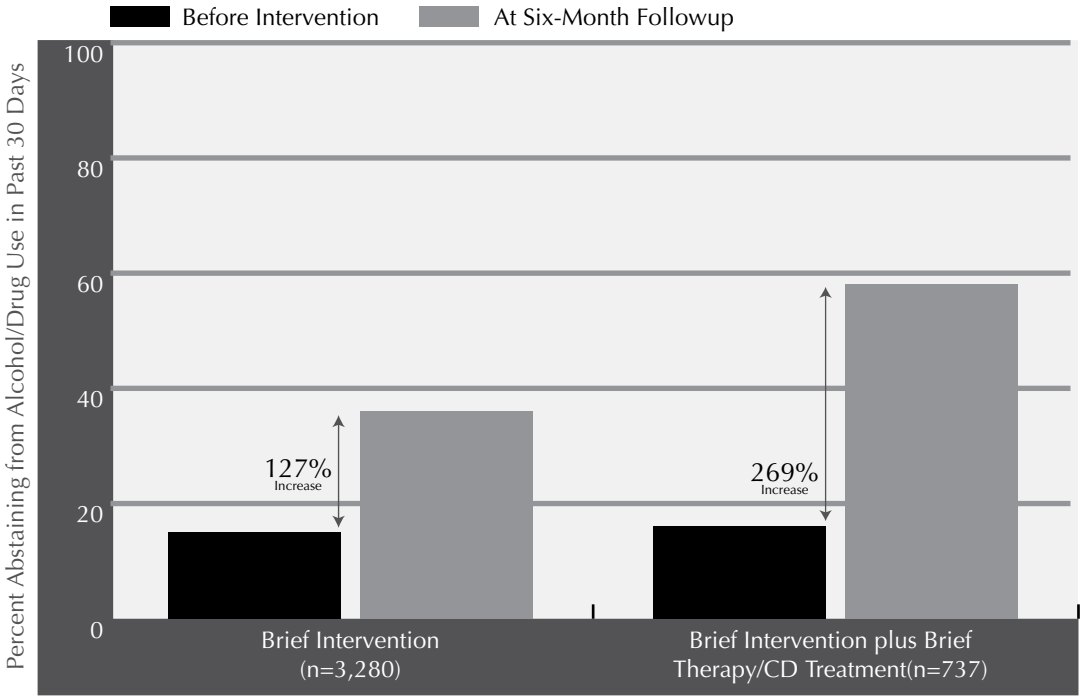
# Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Showed Up in Emergency Departments Resulted in Significant Increases in Abstinence from Illicit Drug Use.




Source: Estee, S., et al., *Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Substance Use Outcomes* - Final Report 4.60.WA.2009.2. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2009.

At the six-month followup, the percentage of those abstaining from illicit drug use in the past 30 days increased significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Abstinence increased by 29% among those who received a brief intervention only, and 64% among those who additionally received brief therapy and/or chemical dependency treatment.

# Brief Intervention, Brief Therapy, and Referral to Chemical Dependency Treatment for Individuals Who Showed Up in Emergency Departments Resulted in Significant Increases in Abstinence from Alcohol and Illicit Drug Use.




Source: Estee, S., et al., *Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Substance Use Outcomes* - Final Report 4.60.WA.2009.2. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2009.

At the six-month followup, the percentage of those abstaining from alcohol and illicit drug use in the past 30 days increased significantly for individuals who received brief interventions as well as those referred for further treatment through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) program. Abstinence increased by 127% among those who received a brief intervention only, and 269% among those who additionally received brief therapy and/or chemical dependency treatment.

# Medical Costs Decreased Among Emergency Department Patients Who Received Brief Interventions for Substance Abuse Problems.

***Total medical savings for Medicaid-only aged, blind, or disabled clients who received at least a brief intervention through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Program was $366 per client per month.[1]***

Following a brief intervention for substance abuse problems (and, when necessary, a referral to brief therapy or chemical dependency treatment), Medicaid aged, blind, or disabled clients who were screened in hospital emergency departments through the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Program experienced a substantial reduction in future medical costs, compared with those who did not receive such an intervention. Potential reductions in total Medicaid costs could have been as high as $4 million per year for working-age disabled clients who would have received at least a brief intervention if the WASBIRT program had been able to continue.[2] Federal funding for the program ended in 2008.

[1] Estee, S., et al. "Evaluation of the Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Project: Cost Outcomes for Medicaid Patients Screened in Hospital Emergency Departments." *Medical Care* (forthcoming).
[2] Estee, S., et al. *Medical Costs Declined for Emergency Department Medicaid Patients – Final Report, 4.61.2009.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, September 2009.

# Student Assistance Prevention Intervention Services Program (SAPISP)

The Student Assistance Prevention Intervention Services Program (SAPISP) is implemented by the Office of Superintendent of Public Instruction with a mix of local, state, and federal funds. Under SAPISP, student assistance specialists are placed in schools to address problems associated with substance use and violence.

The objectives of SAPISP are to:

1. Provide early alcohol and other drug prevention and intervention services to students and their families.
2. Assist in referrals to treatment providers.
3. Strengthen the transition back to school for students who have had substance abuse problems.

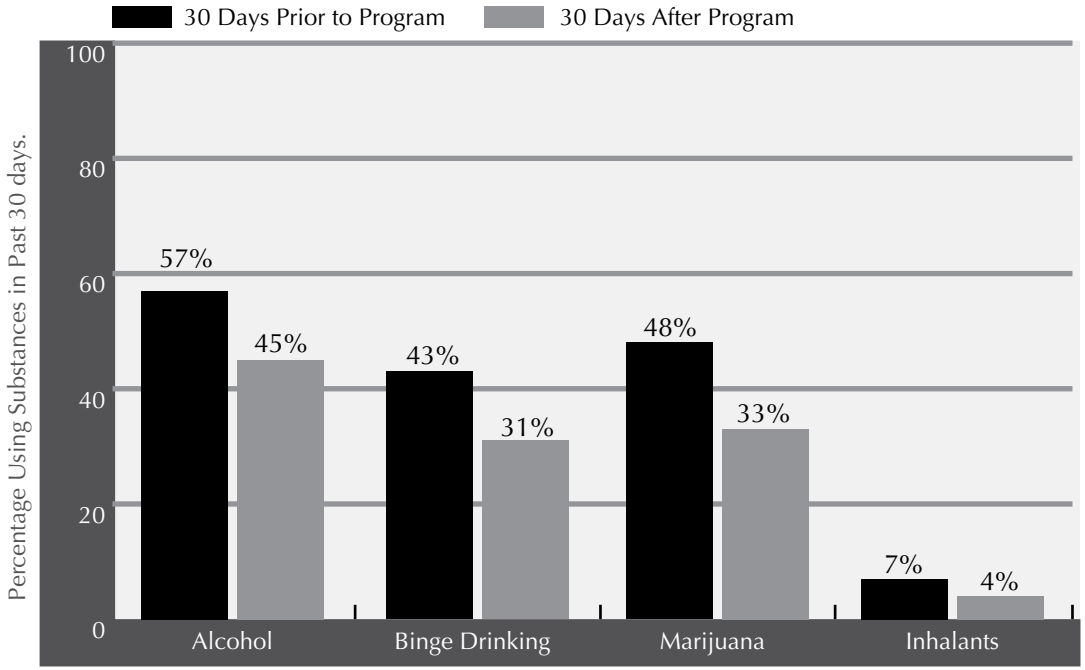
In SFY 2009, $5.2 million was distributed to 13 local grantees, including the four largest school districts in the state (Seattle, Tacoma, Spokane, and Kent), and nine Education Service Districts. Together, they cover most of the state. There are currently 254 prevention intervention specialists in 192 of the 295 Washington school districts, with between 600-800 schools receiving SAPISP services annually.

Invention strategies involve the identification of students who are:

- At risk of initiating substance abuse or antisocial behavior.
- Coping with the substance use of significant others.
- Using tobacco, alcohol, or other drugs.
- Developing a dependence on drugs.

An array of counseling, peer support groups, social skills training, and individual and family interventions are used to address the particular needs of each student. When the severity of use requires services that cannot be provided in the school setting, students are referred to chemical dependency treatment and other services in the community.

# Students Receiving Intervention Services Through the Student Assistance Prevention Intervention Services Program (SAPISP) Reduce Their Substance Use.




Source: Deck, D., and Grunenfelder, D., *Addressing Adolescent Substance Abuse: An Evaluation of Washington's Student Assistance Prevention and Intervention Program – 2007-2008 Annual Report*. Olympia, WA: Office of Superintendent of Public Instruction, Learning and Teaching Support, 2009.

In SFY 2008, students who received intervention services through the SAPISP program with an intervention goal of reducing use report lower use rates 30 days after participating in the program. Rates of alcohol use declined by 21%, binge drinking by 28%, and marijuana use by 31%. As students become older, without intervention, 30-day use rates might reasonably be expected to increase rather than decrease during the school year.[1]

Based on an initial standardized screening, students requiring interventions are referred to community resources, as well as a to an 8-10 session educational support group, usually meeting weekly. Students may also receive individual counseling.

[1] Deck, D., and Grunenfelder, D., *Addressing Adolescent Substance Abuse: An Evaluation of Washington's Student Assistance Prevention and Intervention Program – 2007-2008 Annual Report*. Olympia, WA: Office of Superintendent of Public Instruction, Learning and Teaching Support, 2009.

# Brief Interventions at Washington Colleges and Universities are Targeted to Reduce Alcohol Consumption and Harm Related to Alcohol Use.

Nationwide, approximately two-thirds (66.6%) of U.S. college students drank alcohol in the past 30 days. In 2007, some 41.1% binge drank (had five or more drinks in a row) in the past two weeks. This rate has remained steady over the past decade. Binge drinking peaks at ages 21-22.[1] Those who drink heavily in college are at risk for short-term acute and longer-term chronic problems related to their alcohol use, up to and including alcoholism. While primary prevention and environmental efforts are often aimed at reducing overall alcohol use prevalence, indicated prevention and targeted intervention can be effective in reducing alcohol consumption and harm among those who are already drinking.

***e-Chug ( Electronic Checkup to Go)***

In 2009, 17 Washington college and university campuses - including six community colleges, six private colleges/ universities, and five public colleges/universities – began use of e-Chug. Developed at San Diego State University, e-Chug is an evidence-based approach drawing on both motivational interviewing and social norms feedback theories that can be used as part of a comprehensive campus-wide substance abuse prevention strategy. Students spend 20-30 minutes answering a comprehensive survey that provides them with personalized feedback reports designed to motivate them to reduce alcohol consumption. A companion "personal reflections program" can be utilized with some students to require them to respond to questions designed to deepen their thoughtful examination of their personal choices and the social norms surrounding and influencing their use of alcohol.[2]

***BASICS (Brief Alcohol Screening and Intervention for College Students)***

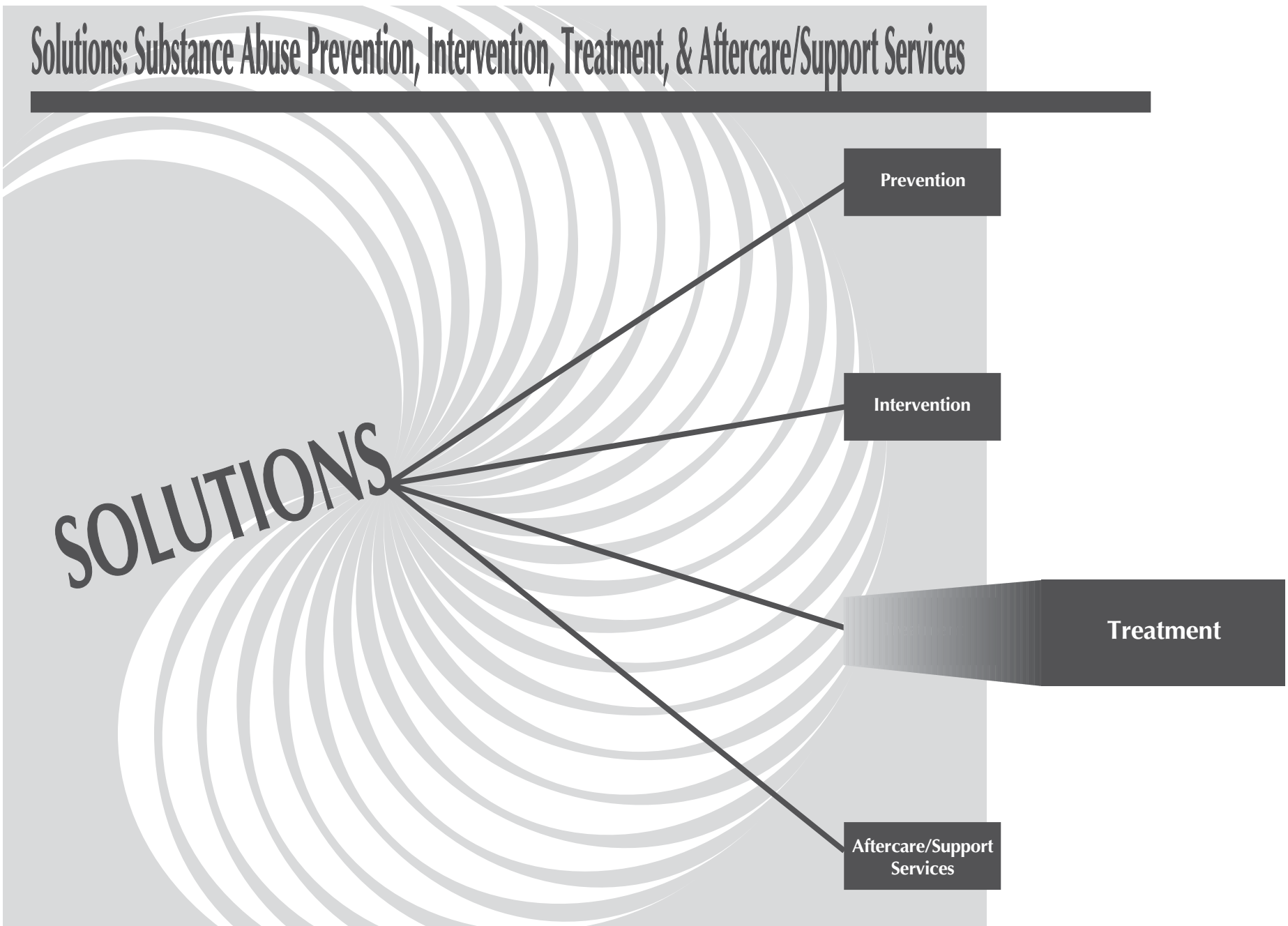
Designed and first implemented at the University of Washington, BASICS is an intervention program aimed at college students who drink heavily and have experienced or at risk for alcohol-related problems. This evidence-based program seeks to motivate students to reduce alcohol use in order to decrease the negative consequences of drinking. BASICS is delivered over the course of two one-hour interviews, with a brief online assessment survey taken by the student after the first session. The first interview gathers information about the student's alcohol consumption patterns and drinking history, personal beliefs about alcohol, while providing instructions for self-monitoring. The second interview compares personal alcohol use with alcohol use norms, reviews individualized negative consequences and risk factors, clarifies perceived risks and benefits of drinking, and provides options to assist in making changes to decrease or abstain from alcohol use. Studies have shown positive short- and long-term impacts.[3]

In the 2007-2009 Biennium, Grays Harbor Community College used BASICS in conjunction with its college athletics department.



[1] Johnston, L., et al. *Monitoring the Future National Survey Results on Drug Use, 1975–2007: Volume II, College Students and Adults Ages 19–45.* Bethesda, MD: National Institute on Drug Abuse, 2008.
[2] More information on the program can be found at www.e-chu.com/coll/
[3] For more information, see the federal Substance Abuse and Mental Health Services Administration, National Registry of Evidence-Based Programs and Practices – nrepp.samhas.gov

# Solutions: Substance Abuse Prevention, Intervention, Treatment, & Aftercare/Support Services



# Introduction

Individuals are eligible for DASA-funded services if they are low-income (generally below 200% of the Federal Poverty Level) or indigent, and are assessed as chemically dependent. For persons applying for treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA), eligibility is further restricted to those who are unemployable as a result of their alcohol or other drug addiction. Additional funds have been allocated to expand treatment access to those who have primary Medicaid eligibility (those receiving General Assistance-Unemployable, General Assistance-Expedited, Supplemental Security Income, and Temporary Assistance to Needy Families). Treatment services are designed to maintain a cost-effective, quality continuum of care for rehabilitating those addicted to alcohol or other drugs. Treatment is also offered for individuals with problem or pathological gambling issues, and is not means-tested.

## *Contracted treatment and support services include:*

- Diagnostic evaluation.
- Alcohol/Drug detoxification.
- Outpatient treatment.
- Opiate substitution (methadone) treatment.
- Intensive inpatient treatment.
- Recovery house.
- Long-term residential treatment.
- Involuntary treatment/civil commitment for individuals with alcohol/drug addiction.
- Youth residential treatment.
- Youth outpatient treatment.
- Residential treatment for pregnant and parenting women (with therapeutic childcare).
- Outpatient treatment for pregnant and parenting women (with childcare).
- Treatment for co-occurring disorders.
- Tribal treatment programs.
- Monolingual programs for non-English speakers.
- Treatment program for the deaf/hard of hearing.
- Urine screening.
- Brief interventions and referral from emergency departments.
- Treatment through drug courts.
- Group care enhancement.
- Outpatient treatment for problem and pathological gambling.
- Support services for those accessing treatment and recovery services.
- Alcohol and Drug 24-Hour Help Line.

### *Specialized contracted support services for eligible individuals include:*

- Child care.
- Translation services (including interpreters for persons who are deaf or hard of hearing).
- Transportation assistance.
- Integrated crisis response/secure detoxification services.
- Case management/Intensive case management.
- Youth outreach.
- Cooperative housing (Oxford House) and other transitional housing support.

### *State and federal funding requirements give priority for treatment and intervention services to the following:*

- Pregnant and postpartum women and families with children.
- Families receiving Temporary Assistance for Needy Families (TANF).
- Child Protective Services referrals.
- Youth.
- Injection drug users (IDUs).
- People with HIV/AIDS.

# DBHR Treatment Philosophy for Alcohol, Tobacco, and Other Drug Addiction

DBHR's program of substance abuse services is based on knowledge gained from scientific research that alcoholism and addiction to other drugs is a progressive disease. Research and evaluation studies cited throughout this report indicate that long periods of sobriety, abstinence, and/or reduced drug use result from effective intervention and treatment. Research also demonstrates that treatment results in a marked reduction in negative consequences for chemically dependent individuals, their families, friends, and society at large, as measured by domestic violence, disrupted families, employment histories, and public costs for law enforcement and the courts, welfare dependence, medical and hospital costs, and admissions to psychiatric hospitals. As alcoholism and addiction are chronic, relapsing disorders, continued treatment and support services may be required after any initial course of treatment.

Alcohol, tobacco, or other drug addiction is an individual, family, worksite, and community affliction. These addictions negatively impact all sectors of society regardless of age, education, race/ethnicity, gender, occupation, or socio-economic status. Therefore, it is critical that all citizens – especially teachers, employers, parents, and youth – understand the illness is treatable and the channels for getting a person into treatment at private or public agencies. DBHR's philosophy recognizes the importance of ensuring all treatment agencies meet established standards for providing services. Treatment must be tailored to the specific needs of each individual, and a continuum of treatment services is essential for matching clients with the optimal types and sequence of interventions. It is also important that specialized treatment services be available for populations with special needs and circumstances, such as adolescents, pregnant and parenting women (and their children), members of minority populations, and those with disabilities.

DBHR recognizes that substance abuse treatment cannot occur in isolation from law enforcement and public safety, educational institutions, and social, health, and economic services. It is essential that substance abuse treatment have linkages with all segments of society that are important to recovery and rehabilitation, and develop recovery-oriented systems of care.

A key aspect of DBHR's philosophy is recognizing the generational cycle of addiction. It is important to break the generational cycle of addiction by promoting alcohol, tobacco, and other drug prevention programs, enrolling children of those who are chemically dependent in appropriate prevention activities, and providing early intervention services when needed.

# Substance Use and Current Need for Treatment

Based on the *2003 Washington State Needs Assessment Survey* conducted by the Department of Social and Health Services' Research and Data Analysis Division, and updated in 2009, 10.7% of the Washington State adult population (age 18 and older) living in households were estimated to be in need of substance abuse treatment in 2008.[1] Treatment need for adolescents (ages 12 to 17) living in households is estimated at 8.7%. (The definition of need for treatment is provided on the following page.)

Alcohol is by far the most used substance in Washington State, and the one for which there is the highest rate of treatment need.

### *Use rates among adults living in households for individual substances were as follows:*

| | Lifetime Use | Past 12-Month Use | Past 30-Day Use |
|---|---|---|---|
| Alcohol | 87.7% | 72.5% | 57.5% |
| Any Illicit Drug | 44.0% | 9.5% | 5.5% |
| Marijuana | 40.9% | 7.3% | 4.3% |
| Methamphetamine | 5.9% | 0.3% | 0.1% |
| Cocaine | 15.1% | 1.1% | 0.4% |
| Heroin | 1.6% | 0.1% | 0.0% |

[1] *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey* (updated 2009). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

## *Current Need for Treatment Among Population Subgroups in Washington State*

Based on data from the *2003 Washington State Needs Assessment Household Survey* conducted by the Department of Social and Health Services' Research and Data Analysis Division and updated for 2008, the current estimated need for treatment varies widely across population subgroups:

- Compared with the overall treatment need rate of 10.7% of adults living in households, some subgroups have lower rates of treatment need. These include: those ages 45-64 (7.7%) and 65+ (1.8%); females (7.1%); Asians (4.7%); and those who are married (7.8%); or widowed (3.6%).
- Other subgroups have higher estimated needs for treatment. These include: those ages 18-24 (23.1%) and 25-44 (13.6%); males (14.5%); American Indians (16.5%) and multi-race individuals (16.4%); and those never married (22.1%).

Need for chemical dependency treatment is associated with income. Adults living in households with incomes above 200% of the Federal Poverty Level (FPL) have lower rates of treatment need (9.8%) than do adults living in households with incomes below 200% FPL (13.5%).

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Those classified as in need of chemical dependency treatment in the past year met one or more of the following conditions:

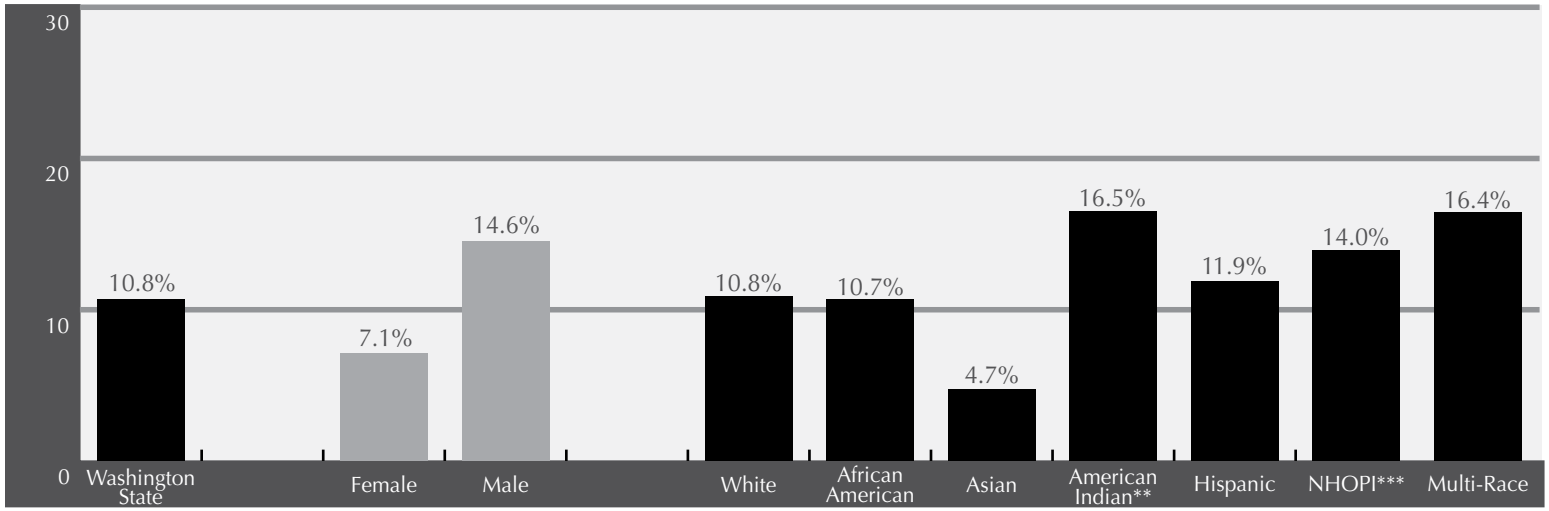
1. Reported life DSM-IV* alcohol or drug abuse or dependence symptoms, reported at least one symptom in the past 12 months, and used alcohol or drugs in the past 12 months.
2. Received professional alcohol or drug treatment (excluding detoxification) during the past 12 months.
3. Reported having a problem with alcohol or drugs and were using alcohol or drugs regularly during the past 12 months. Regular alcohol use is defined as having three or more drinks at least one day per week. Regular drug use is defined as using marijuana 34 or more times in the past 12 months or as using other illicit drugs eight or more times in the past 12 months.
4. Reported heavy use of drugs or alcohol in the past 12 months. Heavy alcohol use is defined as four or more drinks per drinking day, three or more days per week during the past 12 months. Heavy drug use is defined as using any illicit substance 34 or more times during the past 12 months.

**DSM-IV is the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association in 1994. It contains diagnostic criteria for the most common mental disorders, and includes findings on description, diagnosis, treatment, and research.*

# More than One Out of Ten Washington State Adult Residents is in Need of Chemical Dependency Treatment.*

## Current Need for Treatment

Percent of Adults in Households

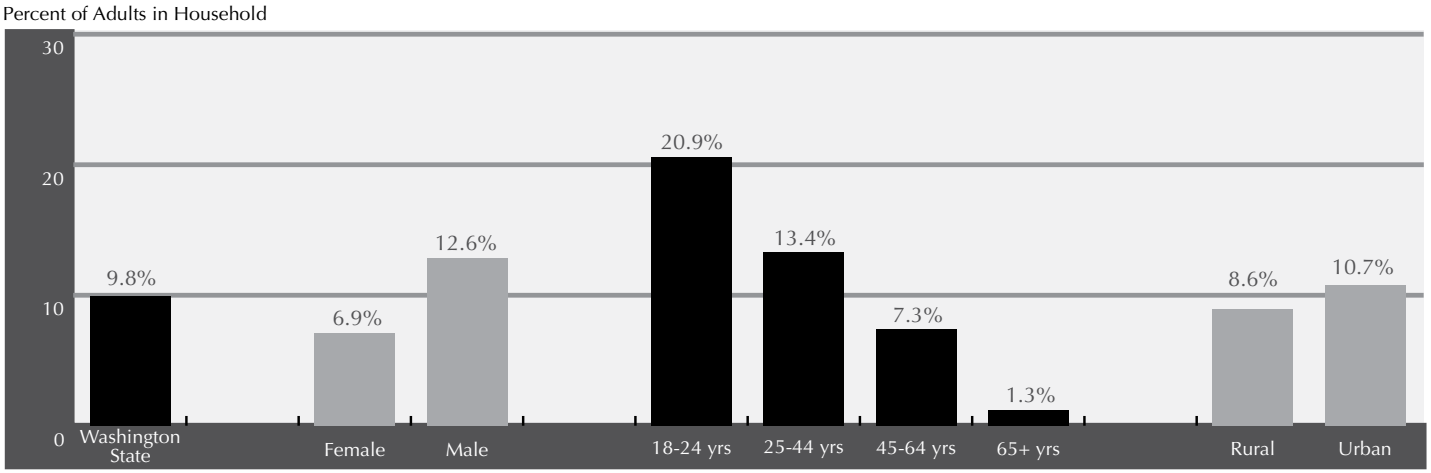



Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey* (updated 2008). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

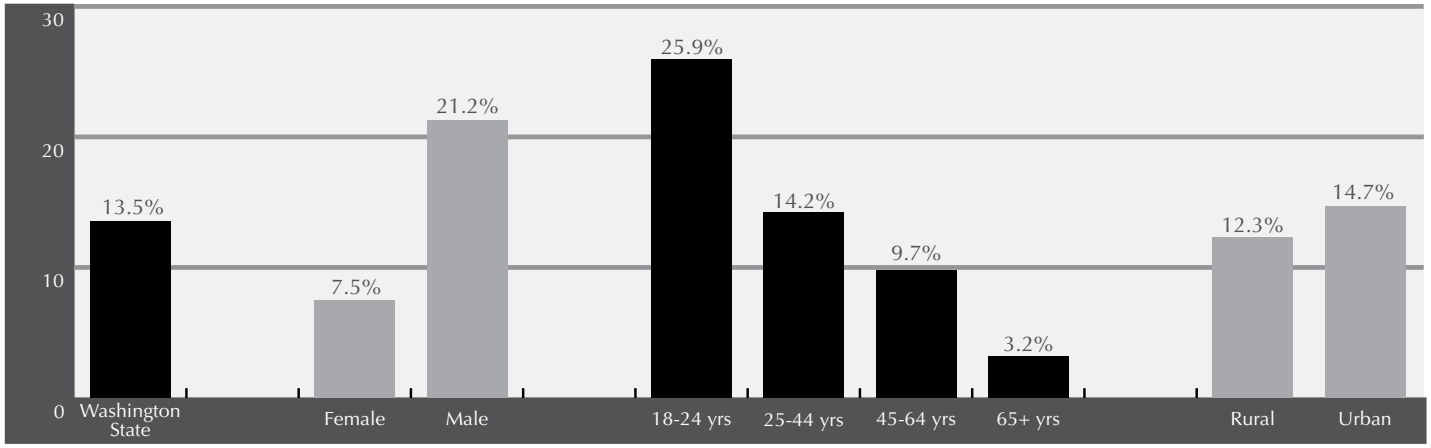
** For definition of Current Need for Treatment, see page 212.*
** American Indian Includes Alaskan Natives.
*** Native Hawaiian or Pacific Islander.

# Younger Adults (Ages 18-24), Males, and Urban Residents Have Higher Rates of Need for Chemical Dependency Treatment.*

## Current Need for Treatment Among Adults Above 200% of Federal Poverty Level




## Current Need for Treatment Among Adults at or Below 200% of Federal Poverty Level



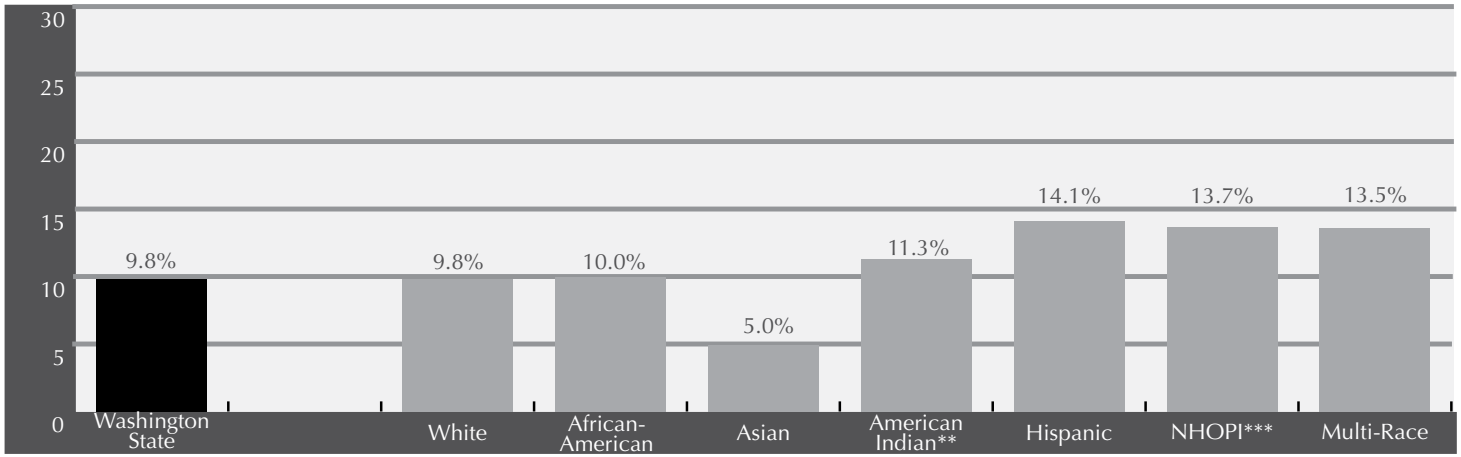

Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey* updated 2008. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

* For definition of Current Need for Treatment, see page 212.

# White, American Indian, and Multi-Race Washington State Adult Residents Have Higher Rates of Chemical Dependency Treatment Need.*

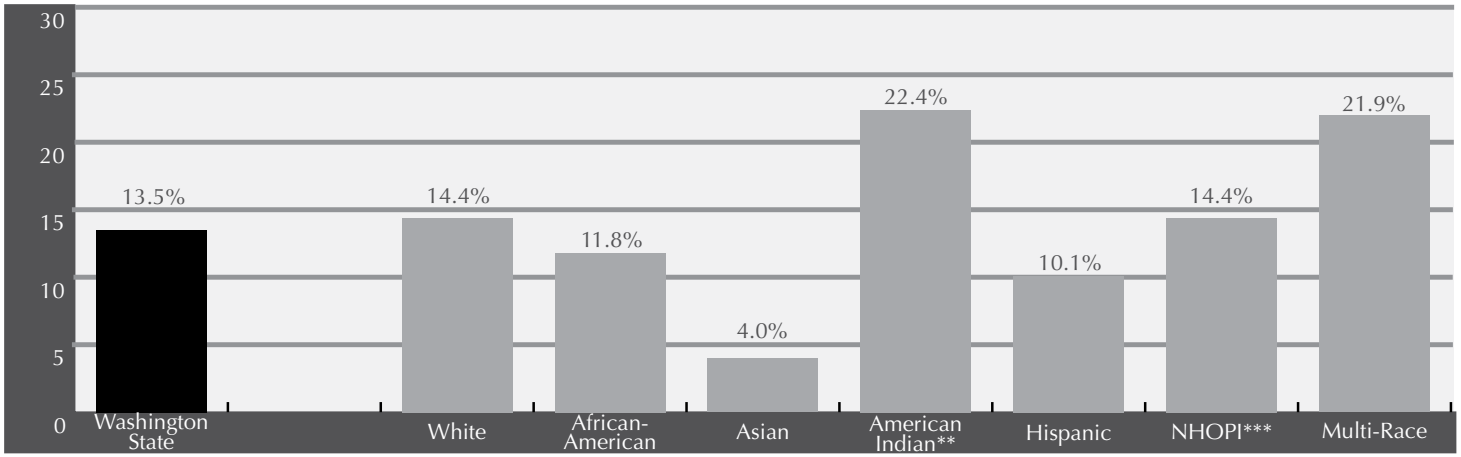
## Current Need for Treatment for Adults Above 200% of the Federal Poverty Level

Percent of Adults in Households




## Current Need for Treatment for Adults at or Below 200% of the Federal Poverty Level

Percent of Adults in Households




Source: *Substance Abuse, Substance Use Disorders, and Need for Treatment in Washington State: Preliminary Findings from the 2003 Washington State Needs Assessment Household Survey* (updated 2008). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

*For definition of Current Need for Treatment, see page 212

**American Indian includes Alaskan Natives.

***Native Hawaiian or Pacific Islander.

# Computing the DBHR Treatment Gap

The Treatment Gap rate is a measure over a given period of time of those who qualify – both clinically and financially – for Division of Behavioral Health and Recovery (DBHR)-funded treatment services but who, because of the limits of available funding, do not receive it. To compute the treatment gap, an estimate is established of all those at or below 200% of the Federal Poverty Level (FPL) and in need of treatment. Those with private insurance, access to military health services, or who are enrolled in the subsidized portion of the Washington Basic Health Plan (BHP) are subtracted from this number, as these individuals would be expected to access chemical dependency treatment services without use of DBHR funds.

The following equation is then used to compute the DBHR Treatment Gap:

$$\textbf{DBHR Treatment Gap Rate} = \frac{\text{\# of county residents qualifying for and requiring DBHR-funded treatment minus those receiving it}}{\text{\# of county residents qualifying for and requiring DBHR-funded treatment}} \times 100$$

The statewide treatment gap is computed by aggregating the county numbers and using the same formula. Counts of persons receiving DBHR-funded treatment are drawn from DBHR's TARGET system. These counts represent cases that were open in SFY 2008. Individuals must have received at least one residential or outpatient service during this period. Persons receiving more than one treatment service are only counted once.

Only those living in households are included. Those residing in institutions or group care settings are excluded from both the numerator and denominator. Results by county are displayed on page 218.

*For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Policy, Planning, Certification, and Legislative Relations, Division of Behavioral Health and Recovery. Address and phone number are found on the back cover.*

# The Treatment Gap

## *SFY 2008 Treatment Gap Rates in Washington State for Publicly Funded Chemical Dependency Services*

| Target Population | Needing & Eligible for DASA-Funded Treatment | Received Treatment with DASA-Funded Support | Number of Eligible Individuals Unserved | Treatment Gap Rate (Unserved Need) |
|---|---|---|---|---|
| Adults with children under 18 | 40,330 | 14,520 | 25,810 | 64.0% |
| Adults without children under 18 | 72,484 | 21,302 | 51,182 | 70.6% |
| **ALL ADULTS 18 AND OLDER** | **112,814** | **35,822** | **76,992** | **68.2%** |
| **ADOLESCENTS (AGES 12 - 17)** | **19,806** | **6,285** | **13,521** | **68.3%** |
| **TOTAL** | **132,620** | **42,107** | **90,513** | **68.2%** |

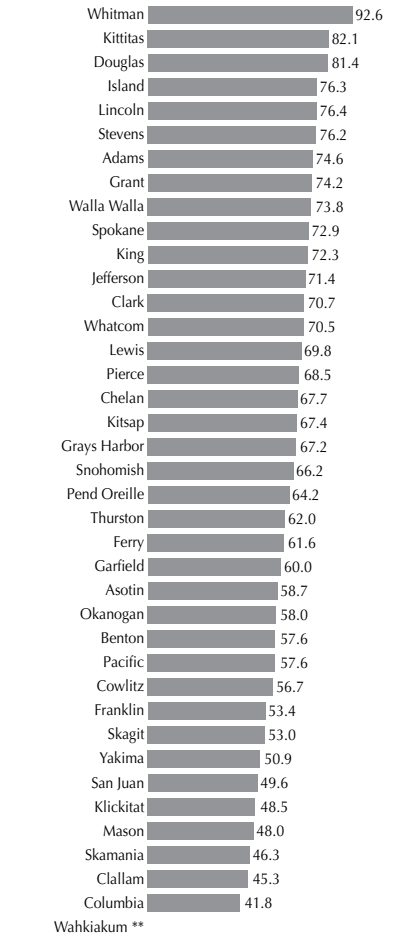
Estimates and treatment data exclude detox, transitional housing, and Department of Corrections. Also excluded are adults who have private, Washington Basic Health Plan, or military health insurance. An additional adjustment was made to include individuals estimated to be eligible for DASA-funded treatment at some time during the 12-month period.

*For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Policy, Planning, Certification, and Legislative Relations, Division of Behavioral Health and Recovery. Address and phone are found on the back cover.*

# Statewide, in SFY 2008, 67.8% of Adults in Households Who Qualified for and were in Need of DASA-Funded Chemical Dependency Treatment Did Not Receive It.*

| County | Percent of Adults <200% FPL & in Need of Treatment & Eligible for DASA-Funded Services | Number of Adults Receiving DASA-Funded Treatment | Number of Eligible Adults Not Receiving DASA-Funded Treatment | Penetration Rate | Treatment Gap |
|---|---|---|---|---|---|
| Adams | 8.5% | 103 | 302 | 25.4% | 74.6% |
| Asotin | 9.4% | 203 | 289 | 41.3% | 58.7% |
| Benton | 9.2% | 1,050 | 1,428 | 42.4% | 57.6% |
| Chelan | 8.7% | 483 | 1.012 | 32.3% | 67.7% |
| Clallam | 9.4% | 766 | 635 | 54.7% | 45.3% |
| Clark | 9.2% | 1,824 | 4,400 | 29.3% | 70.7% |
| Columbia | 8.0% | 53 | 38 | 58.2% | 41.8% |
| Cowlitz | 9.4% | 836 | 1,094 | 43.3% | 56.7% |
| Douglas | 8.5% | 147 | 644 | 18.6% | 81.4% |
| Ferry | 12.1% | 108 | 173 | 38.4% | 61.6% |
| Franklin | 8.3% | 633 | 726 | 46.6% | 53.4% |
| Garfield | 8.8% | 28 | 42 | 40.0% | 60.0% |
| Grant | 9.1% | 537 | 1,543 | 25.8% | 74.2% |
| Grays Harbor | 9.3% | 601 | 1,231 | 32.8% | 67.2% |
| Island | 8.9% | 277 | 893 | 23.7% | 76.3% |
| Jefferson | 8.6% | 162 | 414 | 28.6% | 71.4% |
| King | 9.1% | 7,531 | 19,669 | 27.7% | 72.3% |
| Kitsap | 9.3% | 1,234 | 2,547 | 32.6% | 67.4% |
| Kittitas | 12.8% | 202 | 927 | 17.9% | 82.1% |
| Klickitat | 9.3% | 236 | 222 | 51.5% | 48.5% |
| Lewis | 9.2% | 482 | 1,116 | 30.2% | 69.8% |
| Lincoln | 8.4% | 48 | 155 | 23.6% | 76.4% |
| Mason | 9.5% | 515 | 476 | 52.0% | 48.0% |
| Okanogan | 9.7% | 548 | 757 | 42.0% | 58.0% |
| Pacific | 8.2% | 205 | 276 | 42.6% | 57.6% |
| Pend Oreille | 9.0% | 114 | 204 | 35.8% | 64.2% |
| Pierce | 9.1% | 3,911 | 8,523 | 31.5% | 68.5% |
| San Juan | 8.6% | 139 | 137 | 50.4% | 49.6% |
| Skagit | 8.7% | 980 | 1,106 | 47.0% | 53.0% |
| Skamania | 9.1% | 122 | 105 | 53,7% | 46.3% |
| Snohomish | 8.6% | 3,045 | 5,975 | 33.8% | 66.2% |
| Spokane | 10.4% | 2,689 | 7,223 | 27.1% | 72.9% |
| Stevens | 9.7% | 274 | 878 | 23.8% | 76.2% |
| Thurston | 10.0% | 1,393 | 2,272 | 38.0% | 62.0% |
| Wahkiakum | 10.7% | 54 | 6 | ** | ** |
| Walla Walla | 10.1% | 349 | 982 | 22.2% | 73.8% |
| Whatcom | 11.7% | 1,491 | 3,568 | 29.5% | 70.5% |
| Whitman | 14.0% | 126 | 1,584 | 7.4% | 92.6% |
| Yakima | 8.7% | 2,796 | 2,900 | 49.1% | 50.9% |

## Treatment Gap Rates




*Estimates exclude adults who have private, Washington Basic Health Plan, or military health insurance. An additional adjustment was made to include individuals estimated to be eligible for DASA-funded treatment at some time during the 12-month period.

**Treatment penetrations rates suppressed for counties with 60 or fewer adults estimated to need and be eligible for DASA-funded treatment.

*For a fuller discussion of the methodology used to determine the treatment gap, contact the Office of Policy, Planning, and Legislative Relations, Division of Alcohol and Substance Abuse. Address and phone are found on the back cover.*

# Estimates of Substance Abuse and Treatment Need in Washington State, 2008

| | Adult Household Residents | | Adults In Household at or below 200% of Federal Poverty Level | |
|---|---|---|---|---|
| | # of Residents | % of Residents | # of Residents | % of Residents |
| **NEED FOR TREATMENT** | | | | |
| Current Need for Substance Treatment | 518,219 | 10.7% | 167,776 | 13.5% |
| **ALCOHOL OR DRUG DISORDER** | | | | |
| Lifetime Alcohol or Drug Use Disorder | 963,079 | 20.1% | 251,411 | 20.1% |
| Past 12-Month Alcohol or Drug Use Disorder | 370,294 | 7.7% | 114,923 | 9.3% |
| **ALCOHOL USE DISORDER** | | | | |
| Lifetime Alcohol Use Disorder | 805,599 | 16.8% | 194,158 | 15.6% |
| Past 12-Month Alcohol Use Disorder | 332,860 | 6.9% | 94,158 | 7.6% |
| **DRUG DISORDER** | | | | |
| Lifetime Drug Use Disorder | 334,416 | 7.0% | 115,530 | 9.4% |
| Past 12-Month Drug Use Disorder | 87,530 | 1.8% | 43,734 | 3.5% |
| **ALCOHOL USE** | | | | |
| Lifetime Use of Alcohol | 4,264,833 | 87.7% | 983,848 | 77.0% |
| Past 12-Month Use of Alcohol | 3,507,117 | 72.5% | 734,806 | 58.0% |
| Past 30-Day Use of Alcohol | 2,769,952 | 57.5% | 523,284 | 41.4% |
| **USE OF ANY ILLICIT DRUG** | | | | |
| Lifetime Use of Any Illicit Drug | 2,100,268 | 44.0% | 509,446 | 40.7% |
| Past 12-Month Use of Any Illicit Drug | 455,415 | 9.5% | 155,521 | 12.6% |
| Past 30-Day Use of Any Illicit Drug | 265,688 | 5.6% | 92,301 | 7.5% |
| **MARIJUANA USE** | | | | |
| Lifetime Use of Marijuana | 1,948,647 | 40.9% | 464,895 | 37.3% |
| Past 12-Month Use of Marijuana | 343,881 | 7.3% | 117,482 | 9.5% |
| Past 30-Day Use of Marijuana | 204,566 | 4.3% | 71,697 | 5.8% |
| **METHAMPHETAMINE** | | | | |
| Lifetime Use of Meth | 280,208 | 5.9% | 90,882 | 7.4% |
| Past 12-Month Use of Meth | 16,943 | 0.3% | 11,558 | 0.9% |
| Past 30-Day Use of Meth | 5,734 | 0.1% | 4,411 | 0.3% |
| **COCAINE USE** | | | | |
| Lifetime Use of Cocaine | 718,417 | 15.1% | 188,619 | 15.1% |
| Past 12-Month Use of Cocaine | 53,606 | 1.1% | 24,859 | 2.0% |
| Past 30-Day Use of Cocaine | 16,985 | 0.4% | 8,017 | 0.6% |

Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

# Estimates of Current Need for Substance Abuse Treatment in Washington State, 2008

| | Adult Household Residents 200% of Federal Poverty Level | | | Adults In Household at or below | | |
|---|---|---|---|---|---|---|
| GROUP | Population | # Needing Treatment | % Needing Treatment | Population | # Needing Treatment | % Needing Treatment |
| Total | 4,825,488 | 518,219 | 10.7% | 1,246,218 | 167,776 | 13.5% |
| **AGE** | | | | | | |
| 18-24 | 577,058 | 133,378 | 23.1% | 257,703 | 66,676 | 25.9% |
| 25-44 | 1,796,225 | 244,902 | 13.6% | 485,757 | 69,008 | 14.2% |
| 45-64 | 1,619,117 | 124,530 | 7.7% | 247,346 | 23,977 | 9.7% |
| 65+ | 833,088 | 15,409 | 1.8% | 255,413 | 8,115 | 3.2% |
| **SEX** | | | | | | |
| Male | 2,372,128 | 344,821 | 14.5% | 545,192 | 115,512 | 21.2% |
| Female | 2,453,359 | 173,398 | 7.1% | 701,026 | 52,264 | 7.5% |
| **RACE/ETHNICITY** | | | | | | |
| White-NH | 3,916,456 | 423,465 | 10.8% | 873,227 | 126,139 | 14.4% |
| Black-NH | 137,773 | 14,748 | 10.7% | 53,411 | 6,300 | 11.8% |
| Asian | 270,130 | 12,664 | 4.7% | 77,146 | 3,069 | 4.0% |
| Amer. Indian* | 64,922 | 10,719 | 16.5% | 30,730 | 6,871 | 22.4% |
| NHOPI** | 31,272 | 4,372 | 14.0% | 13,094 | 1,884 | 14.4% |
| Multi-Race | 87,169 | 14,283 | 16.4% | 29,696 | 6,499 | 21.9% |
| Hispanic | 317,765 | 37,968 | 11.9% | 168,914 | 17,014 | 10.1% |
| **MARITAL** | | | | | | |
| Married | 2,841,240 | 219,904 | 7.7% | 528,226 | 52,583 | 10.0% |
| Div/Sep | 715,082 | 78,993 | 11.0% | 248,291 | 25,722 | 10.4% |
| Widowed | 326,940 | 11,519 | 3.5% | 138,459 | 4,950 | 3.6% |
| Never Mar | 942,226 | 207,803 | 22.1% | 331,242 | 84,522 | 25.5% |
| **EDUCATION** | | | | | | |
| Not HS Grad | 426,988 | 46,448 | 10.9% | 260,469 | 27,095 | 10.4% |
| HS Graduate | 4,398,499 | 471,771 | 10.7% | 985,749 | 140,680 | 14.3% |
| **URBAN** | | | | | | |
| Not HS Grad | 2,177,180 | 209,813 | 9,6% | 617,778 | 75,699 | 12,3% |
| HS Graduate | 2,648,308 | 308,406 | 11.6% | 628,440 | 92,076 | 14.7% |
| **POVERTY** | | | | | | |
| Below 200% | 1,246,218 | 167,776 | 13.5% | 1,246,218 | 167,776 | 13.5% |
| Above 200% | 3,579,270 | 350,443 | 9.8% | - | - | - |

*American Indian includes Alaskan Native

**Native Hawaiian or Pacific Islander

Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

# Modality categories are defined as follows:

## *Detoxification*

Detoxification is a short-term residential service for individuals withdrawing from the effects of excessive or prolonged alcohol or drug abuse. Services continue only until the person recovers from the transitory effects of acute intoxication. Detoxification always includes supervision and may include counseling and/or medical care and use of pharmacological agents. Some counties provide detoxification in specialized freestanding facilities; in other counties, detoxification is provided in community hospitals. DASA now has two pilot intensive crisis response/secure detoxification programs in Pierce and the North Sound Counties.

## *Intensive Inpatient*

Intensive inpatient treatment is a highly structured program for chemically dependent persons in a residential setting. Services emphasize alcohol and drug education and individual and group therapy. The length of stay in intensive inpatient treatment for adults is based on American Society for Addiction Medicine (ASAM) criteria.

## *Recovery House*

Recovery houses provide social, recreational, and occupational therapy as well as treatment in a drug/alcohol-free residential setting. The program emphasizes helping patients re-enter the community and the outpatient phase of treatment.

## *Long-Term Residential*

Long-term residential treatment is a specialized program for chemically dependent persons who require periods of treatment in excess of 90 days. It includes domiciliary care, counseling, and other therapies to patients who reside at the treatment facility. Individuals who are chronically chemically dependent or present a likelihood of serious harm to themselves or others, or are gravely disabled by alcohol or other drug addiction, may be committed to long-term residential treatment under the Involuntary Treatment Act.

## Other Residential

This category includes transitional housing, residential treatment for co-occurring chemical dependency and mental health disorders, and on-site group care enhancement services for youth and adults.

Transitional housing provides pregnant and parenting women who have completed chemical dependency treatment with up to 18 months of housing. In conjunction with the housing component, women receive case management services that monitor participation in off-site treatment, prepare clients for self-sufficiency, and link women and their children to other needed services.

Co-occurring disorders programs are provided in residential chemical dependency treatment facilities. Utilizing a group care enhancement model, mental health professionals at the facilities provide assessment, education, in-service training for staff, and linkages to mental health providers in the community.

Through group care enhancement contracts, adolescent chemical dependency treatment providers are able to deliver on-site services to children residing in Department of Social and Health Services children's residential facilities. These include select group homes operated by the Division of Children and Family Services, the Mental Health Division, and the Juvenile Rehabilitation Administration. Providers are able to provide individual drug and alcohol assessments; individual, group, and family treatment; prevention and education groups; training of residential agency staff; case planning and consultation; and linkages to other community alcohol and drug services.

New group care enhancement contracts also make it possible for providers to deliver on-site services to adults living in nursing homes and assisted living facilities under the Treatment Expansion initiative.

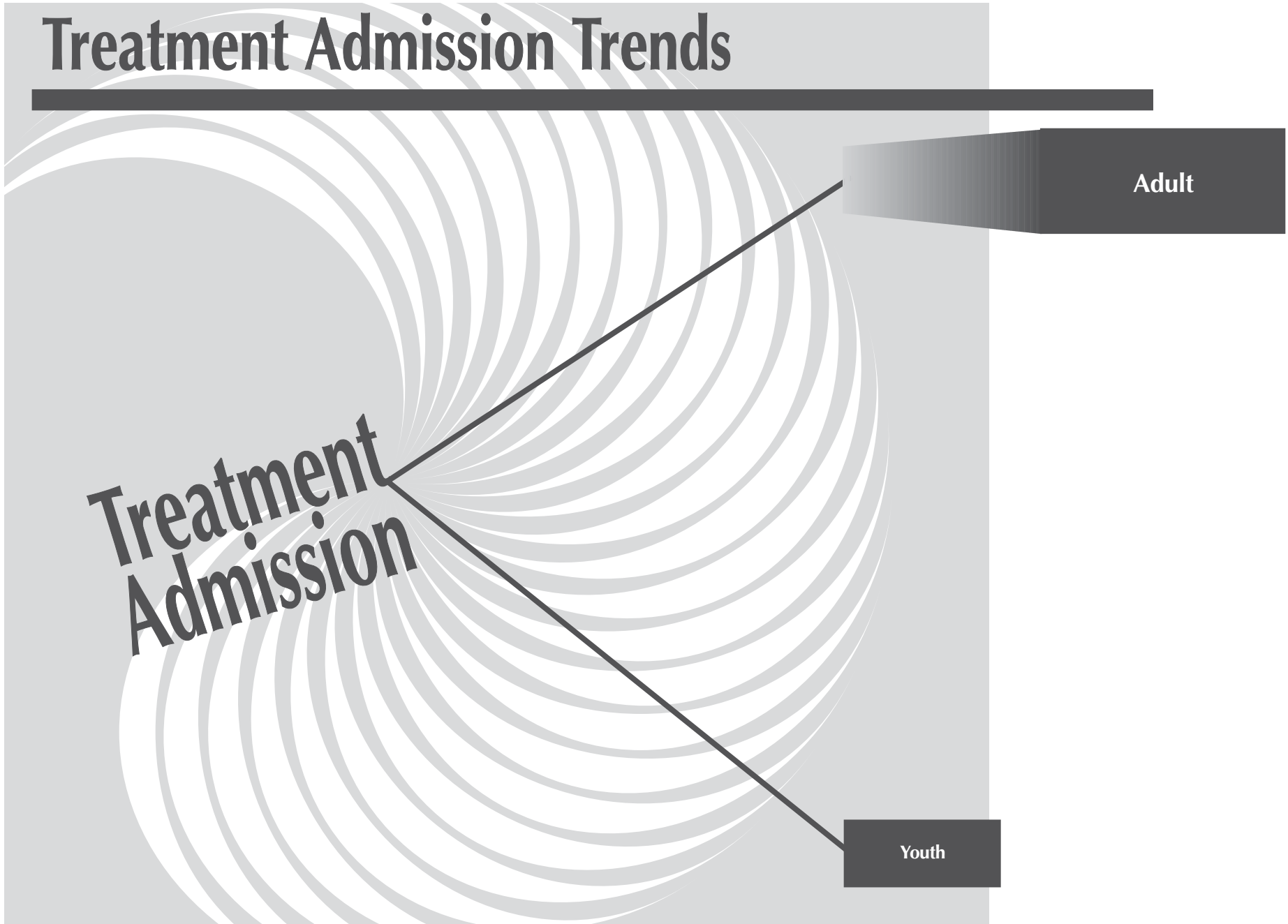
## Outpatient and Intensive Outpatient Treatment

Outpatient treatment services consist of a variety of diagnostic and treatment services provided according to a prescribed treatment plan in a non-residential setting. Outpatient treatment provided for indigent patients under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) includes vocational counseling and other efforts to help patients regain employment.

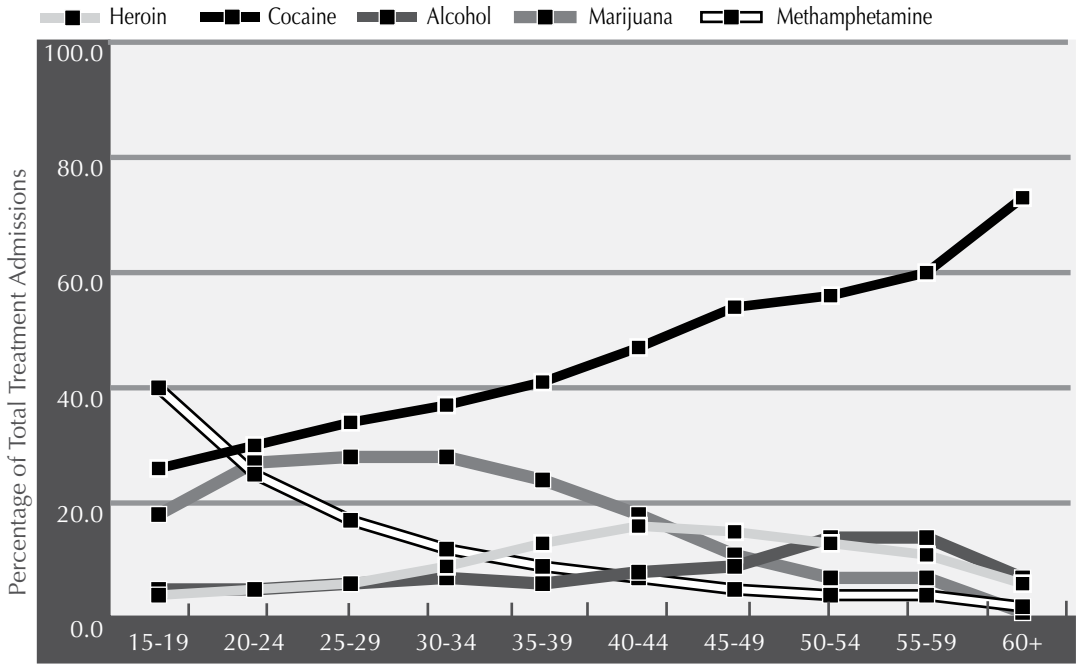
## Opiate Substitution Treatment

Opiate substitution treatment is an outpatient service for individuals addicted to heroin or other opiates. State-funded and accredited opiate substitution treatment agencies provide counseling and daily or near-daily administration of methadone or other approved substitute drugs.

# Treatment Admission Trends



# Primary Drug of Abuse in Adult DASA-Funded Treatment Admissions Varies Significantly By Age.*

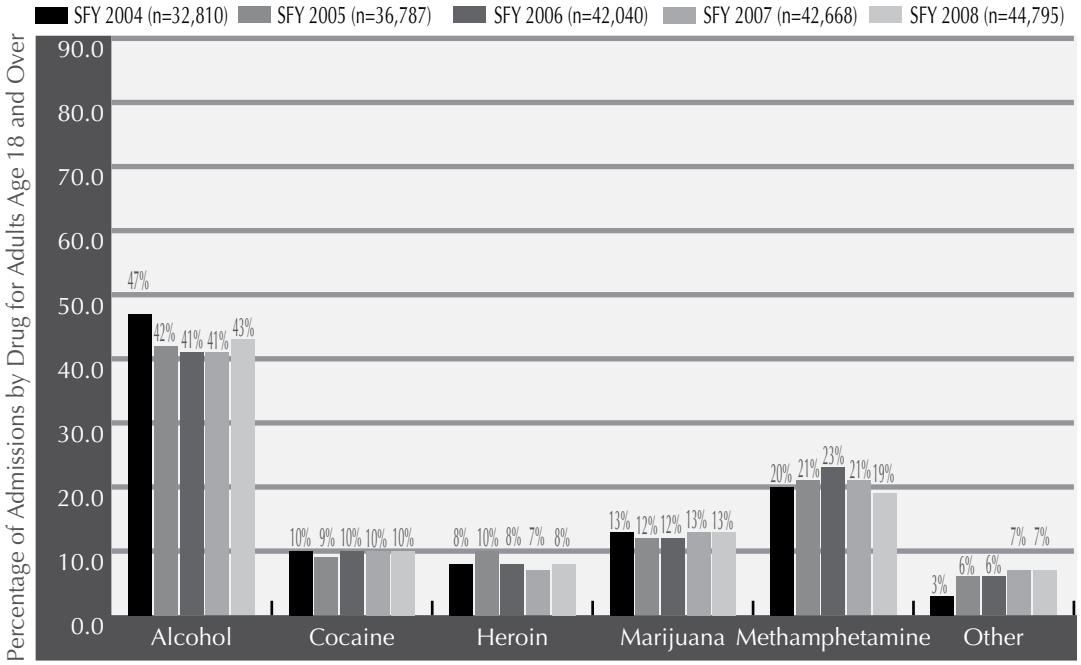



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2009.

Primary drug of abuse upon treatment admission reflects drug use in the wider population. This graph indicates that adult DASA-funded admissions by primary drug of abuse vary widely by age cohort. As a percentage of treatment admissions by age cohort, admissions for alcohol and heroin rise as patients get older until age 50, when they diverge. Marijuana admissions are highest for the youngest cohort; methamphetamine admissions are high for patients in their 20s and 30s.

**Excludes detoxification and transitional housing.*

# Alcohol Continues to Be Cited as the Primary Drug of Abuse in the Plurality of Adult Admissions to DASA-Funded Treatment.*




Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2009.

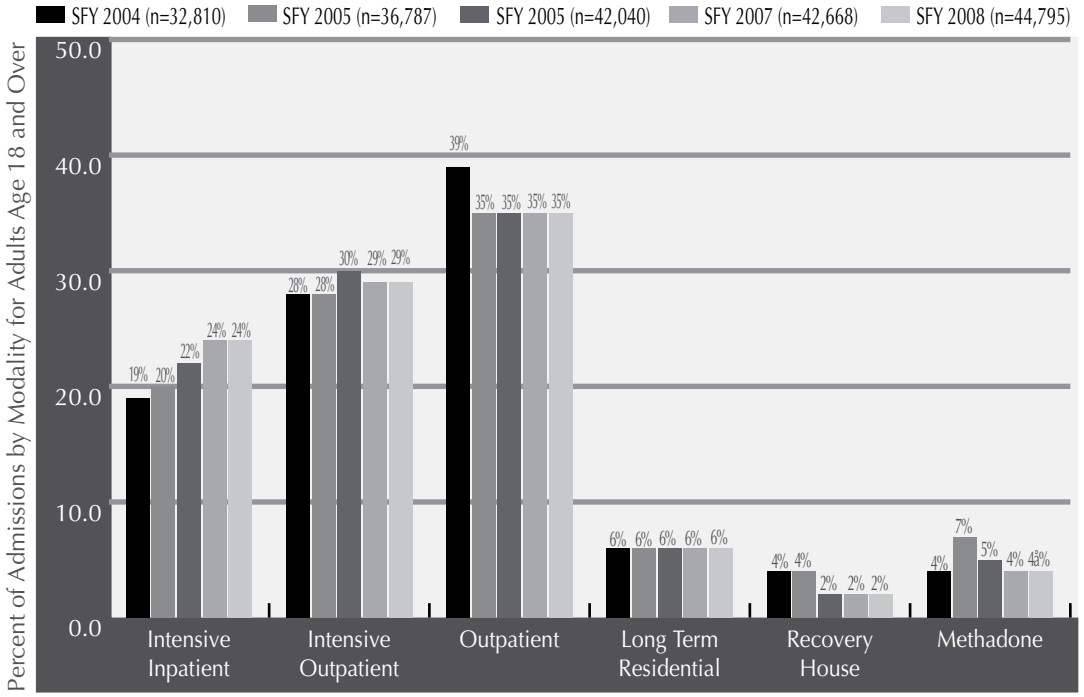
This graph indicates that in SFY 2008, alcohol remained the primary drug of abuse for adult admissions to DASA-funded treatment. The number of alcohol-related admissions has risen substantially, from 15,098 in SFY 2004 to 18,985 in SFY 2008, representing a 25.7% increase. Adult admissions to treatment for methamphetamine addiction fell by 5.8% between SFY 2007 and SFY 2008. Admissions where other non-heroin opiates or synthetics, oxycodone/hydrocodone, or prescribed opiate substitute are indicated as primary drug of abuse have risen from 843 in SFY 2004 to 2,641 in SFY 2008, representing a 213% increase.

The number of total adult admissions to DASA-funded treatment has increased 36.5% since SFY 2004. This reflects new avenues to access treatment as a result of the continuing treatment expansion initiative, funding through the Criminal Justice Treatment Account (CJTA), and increased availability of opiate substitution treatment.

Note: Data may include multiple admissions for a single individual over the course of a year.

**Excludes detoxification and transitional housing.*

# Almost Two-Thirds of Adult Admissions to DASA-Funded Treatment are for Outpatient and Intensive Outpatient Services.*

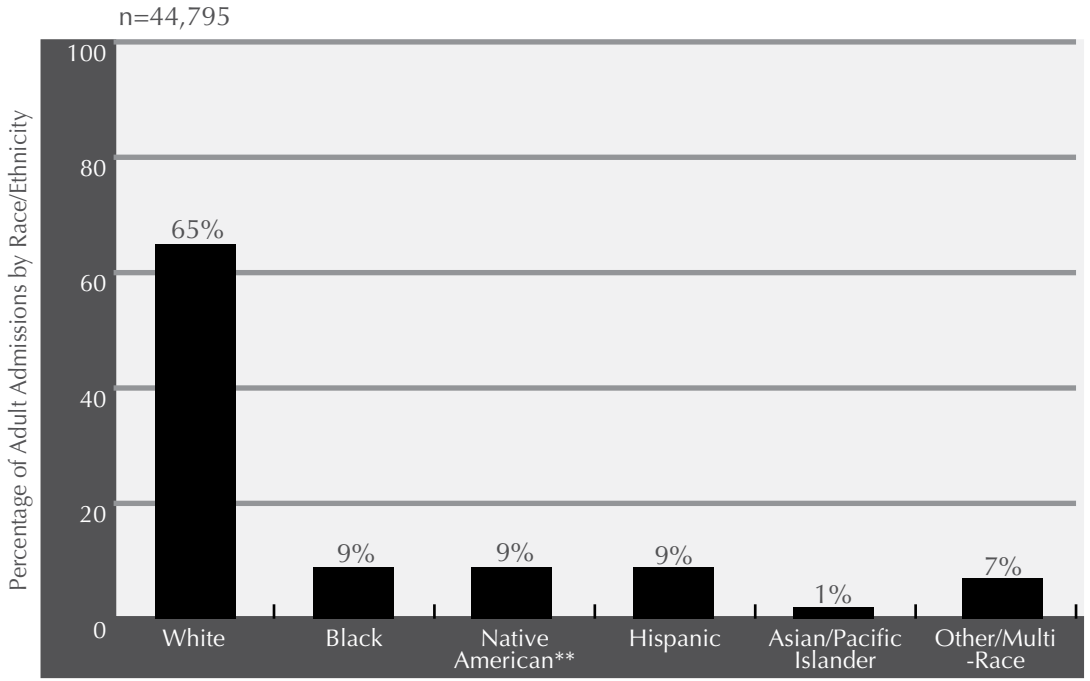



Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

This graph indicates that almost two-thirds of adult admissions to DASA-funded chemical dependency treatment are for intensive outpatient and outpatient services. The total number of adult admissions has risen 36.5% since SFY 2004, reflecting new avenues for treatment access as a result of the legislatively mandated treatment expansion for Medicaid-eligible clients and funding through the Criminal Justice Treatment Account (CJTA). Intensive inpatient admissions rose from 6,172 in SFY 2004 to 10,551 in SFY 2008, representing a 70.9% increase.

** Excludes detoxification and transitional housing.*

# In SFY 2008, Racial and Ethnic Minorities Comprised 35% of Adult Admissions to DASA-Funded Chemical Dependency Treatment Services.

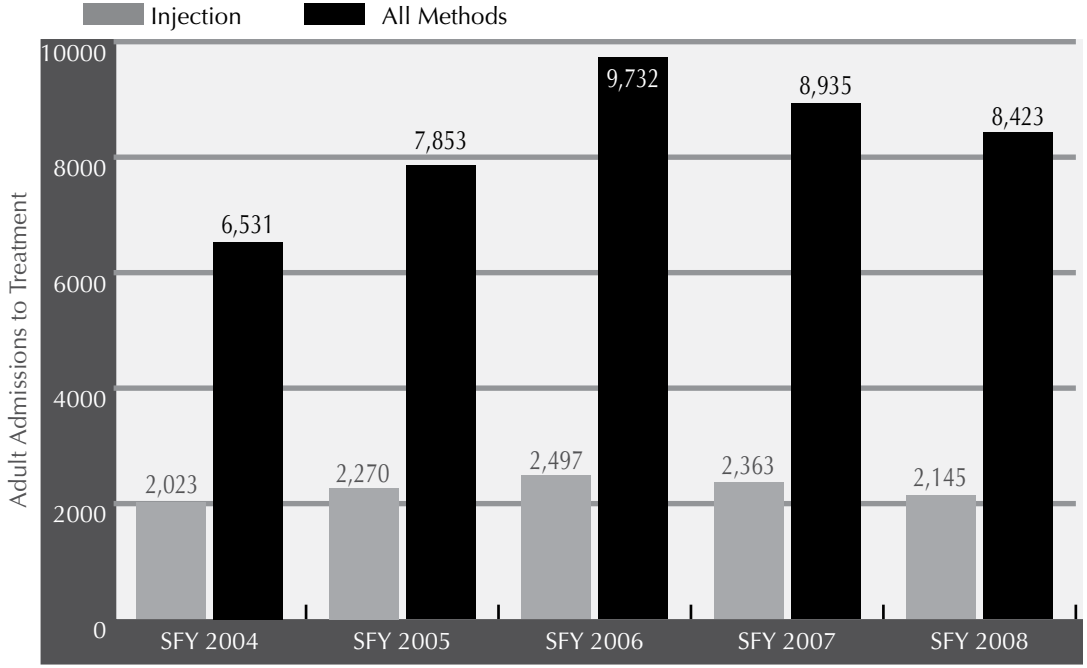



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

This graph indicates that racial/ethnic minorities comprise approximately 35% of adult admissions to DASA-funded chemical dependency treatment. Percentages of adults from different groups receiving DASA-funded treatment vary across modalities.

** Includes Eskimo/Alaskan Native/Aleut*

# The Number of Adults Admitted to DASA-Funded Treatment for Methamphetamine Has Fallen for the Second Year in a Row.




Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

The number of adults admitted to DASA-funded treatment for methamphetamine is now falling, and in SFY 2008 declined 13.5% from its high in SFY 2006. This parallels the precipitous decline in the number of methamphetamine laboratories and dumpsites in Washington State now being reported to the Department of Ecology. The majority of adults admitted to DASA-funded treatment for methamphetamine administer the drug via routes other than injection. A large majority of individuals dependent on methamphetamine are polydrug users.

Treatment for methamphetamine addiction has been demonstrated to be effective in reducing arrests, convictions, and health care costs.[1]

[1] Nordlund, D., et al. *Treatment of Stimulant Addiction Including Addiction to Methamphetamine Results in Lower Health Care Costs and Reduced Arrests and Convictions: Washington State Supplemental Security Income Recipients.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

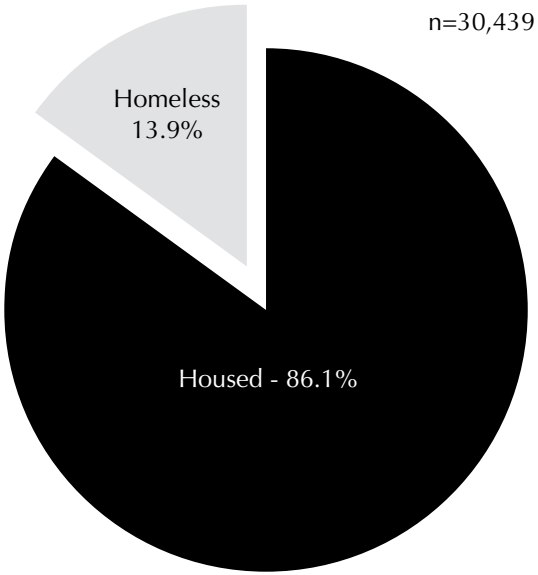
# Comparison of Adults Addicted to Heroin and Prescription-Type Opiates Admitted to DASA-Funded Opiate Substitution Treatment, 2006-2007

| | Heroin | Prescription-Type Opiates* |
|---|---|---|
| Number of Individuals | 2,364 (68.6% of total) | 1,082 (31.4% of total) |
| Median Age | 42 | 32 |
| Gender | 55% male/45% female | 38% male/62% female |
| Employment Status | 8% employed full- or part-time | 19% employed full- or part-time |
| Race | Caucasian – 77%; African-American – 11%; Asian/Pacific Islander – 1%; American Indian – 5%; Other/Multi-Race – 6%. Hispanic Origin – 6%. | Caucasian – 78%; African-American – 4%; Asian-Pacific Islander – 2%; American Indian – 13%; Other/Multi-Race – 3%. Hispanic Origin – 5%. |
| % with Previous Admission | 51% | 32% |
| % with Treatment Readmission | 18% | 14% |
| Criminal Justice Involvement | 43% arrested at least once in previous year | 28% arrested at least once in previous year |
| % with Children in the Home | 21% | 45% |
| % with Co-Occurring Disorders | 44% with co-occurring mental disorder | 32% with co-ocurring mental disorder |
| Housing Status | 20% homeless** | 6% homeless** |
| % Injection Drug Users | 100% | 3% |
| % in Treatment 1-90 days | 19% | 17% |
| % in Treatment 91-180 days | 15% | 14% |
| % in Treatment 181-270 days | 11% | 8% |
| % in Treatment 271-365 days | 9% | 7% |
| % in Treatment > 365 days | 46% | 53% |

**Less than 1% are for drugs other than opiates. Prescription-type opiates include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oyxcodone, and propoxyphene. Morphine is classed with heroin.*

***Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

# Approximately 14% of Individuals Admitted to DASA-Funded Chemical Dependency Treatment Services are Homeless at Time of Admission.*




Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, 2009.

In SFY 2008, there were 4,228 individuals who were homeless admitted to DASA-funded treatment services. They are significantly more likely to be admitted to residential treatment (72%) than housed patients (28%).

Compared with housed patients, homeless patients admitted to treatment are more likely to be: older (median age 38 v. 33); male (65% v. 60%), and African-American (17% v. 8%). They are less likely to have alcohol as their primary substance of abuse (39% v. 45%), and more likely to have, cocaine (15% v. 9%), or heroin (13% v. 7%) as their primary substance of abuse. They are less likely to have been arrested in the previous year (58% v. 63%), more likely to inject drugs (18% v. 11%), and less likely to be employed full- or part-time (6% v. 22%).

Through its Access to Recovery (ATR) program in six counties, DASA provides housing assistance to support individuals in their recovery.

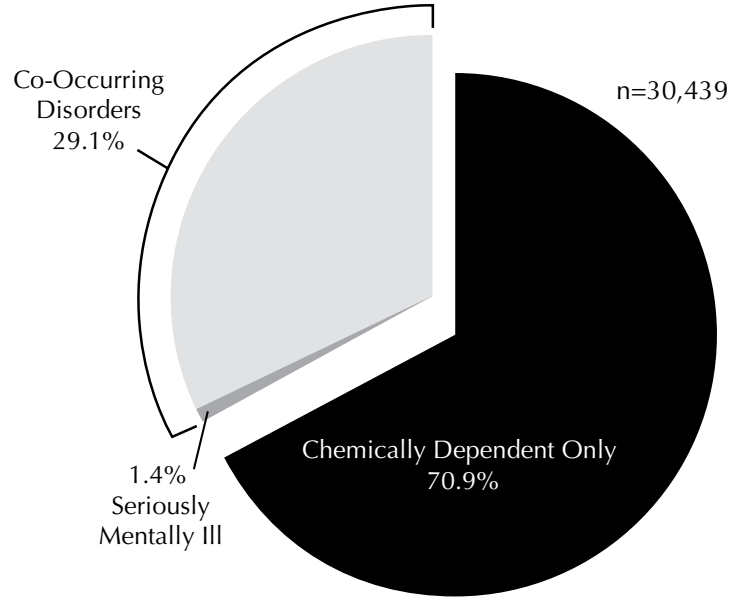
**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

# Comparison of Adults Who are Homeless and Those Who are Housed Admitted to DASA-Funded Treatment, SFY 2008

| | Homeless* | In Housing |
|---|---|---|
| Number of Individuals | 4,228 (13.9% of total) | 26,2111 (86.1% of total) |
| Median Age | 38 | 33 |
| Gender | 68% male / 32% female | 60% male / 40% female |
| Race/Ethnicity | Caucasian - 65%; African-American - 17%; Asian/Pacific Islander - 1%; American Indian - 7%; Multi-Racial/Other Race - 10%. Hispanic Origin - 6% | Caucasian - 68%; African-American - 8%; Asian/Pacific Islander - 2%; American Indian - 10%; Multi-Racial/Other Race - 13%. Hispanic Origin - 11% |
| Employment Status | 6% employed full- or part-time | 22% employed full- or part-time |
| Primary Drug | Alcohol - 39%; Methamphetamine - 18%; Cocaine - 15%; Heroin - 13% | Alcohol - 45%; Methamphetamine - 17%; Marijuana - 14% |
| % with Previous Admission | 56% | 51% |
| Criminal Justice Involvement | 58% arrested at least once in previous year | 61% arrested at least once in previous year |
| % with Children in the Home | 7% | 28% |
| % with Co-Occurring Disorder | 37% | 28% |
| Completion Rate Residential/Outpatient | 71% / 38% | 77% / 51% |

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

# Approximately 29% of Individuals Admitted to DASA-Funded Chemical Dependency Treatment Services Have Co-Occurring Mental Health and Chemical Dependency Disorders.




Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2009.

Individuals with co-occurring disorders are defined as patients who are receiving mental health services at the time they enter chemical dependency treatment or are determined at their intake assessment to be in need of such services. At the assessment, chemical dependency professionals inquire as to past psychological assessments or evaluations, past-year psychiatric hospitalizations, and the use of medications for mental health disorders.

Integrated treatment for mental health and chemical dependency disorders has proven effective in enhancing health-related outcomes and reducing use of acute care services.[1] Beginning in January 2007, DASA and DSHS Mental Health Division treatment providers serving publicly funded patients started using a common co-occurring disorders screening and assessment process.

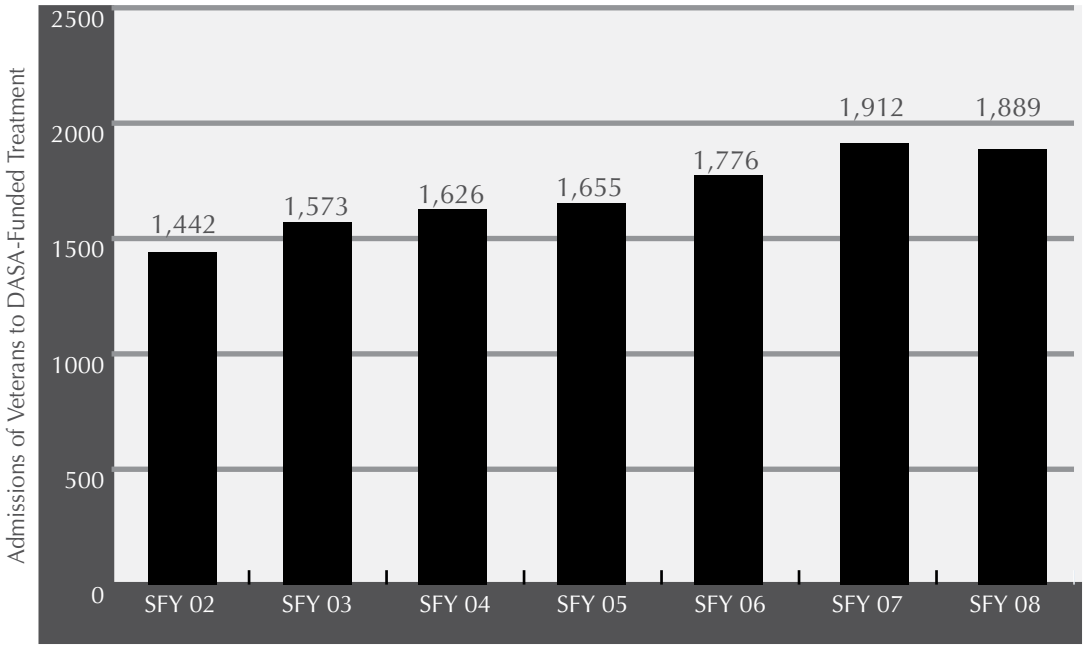
[1] Maynard, C., et al. "Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment," *The Journal of Behavioral Health Services & Research* 26(2), May 1999.

# Comparison of Adults with Co-Occurring Chemical Dependency and Mental Health Disorders and Non-Co-Occurring Patients Admitted to DASA-Funded Treatment, SFY 2008

| | Co-Occurring | Non-Co-Occurring |
|---|---|---|
| Number of Individuals | 8,856 (29.1% of total) | 21,583 (70.9% of total) |
| Median Age | 37 | 32 |
| Gender | 48% male / 52% female | 68% male / 32% female |
| Race/Ethnicity | Caucasian - 73%; African American - 11%; Asian/Pacific Islander - 2%; American Indian - 7%; Multi-Racial/Other Race - 9%. Hispanic Origin - 6% | Caucasian - 65%; African American - 9%; Asian/Pacific Islander - 2%; American Indian - 10%; Multi-Racial/Other Race - 14%. Hispanic Origin - 12% |
| Employment Status | 8% employed full- or part-time | 25% employed full- or part-time |
| Primary Drug | Alcohol - 39%; Methamphetamine - 19%; Cocaine - 12%; Marijuana - 12% | Alcohol - 46%; Methamphetamine - 17%; Marijuana - 14% |
| % with Previous Admission | 55% | 42% |
| Criminal Justice Involvement | 53% arrested at least once in previous year | 63% arrested at least once in previous year |
| % with Children in the Home | 22% | 26% |
| Housing Status | 18% homeless* | 12% homeless* |
| Completion Rate (residential/outpatient) | 74% / 42% | 76% / 53% |

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

# The Number of Admissions of Military Veterans to Publicly Funded Treatment Has Grown By More than a Third Since SFY 2002.




Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

The number of military veterans receiving DASA-funded treatment has grown significantly in recent years. Compared to non-veterans admitted to treatment in SFY 2008, veterans are significantly older (median age 46 v. 33 for non-veterans), more likely to be male (93% v. 60%), less likely to have children in the home (11% v. 26%), and more likely to have alcohol as their primary substance of abuse (59% v. 43%).

Military veterans returning home from Iraq and Afghanistan suffer from high rates of post-traumatic stress disorder, traumatic brain injuries, depression, suicide, and substance abuse.[1] As the number of returning veterans increases, providing needed substance abuse and mental health resources will likely prove a challenge to state and federal agencies.

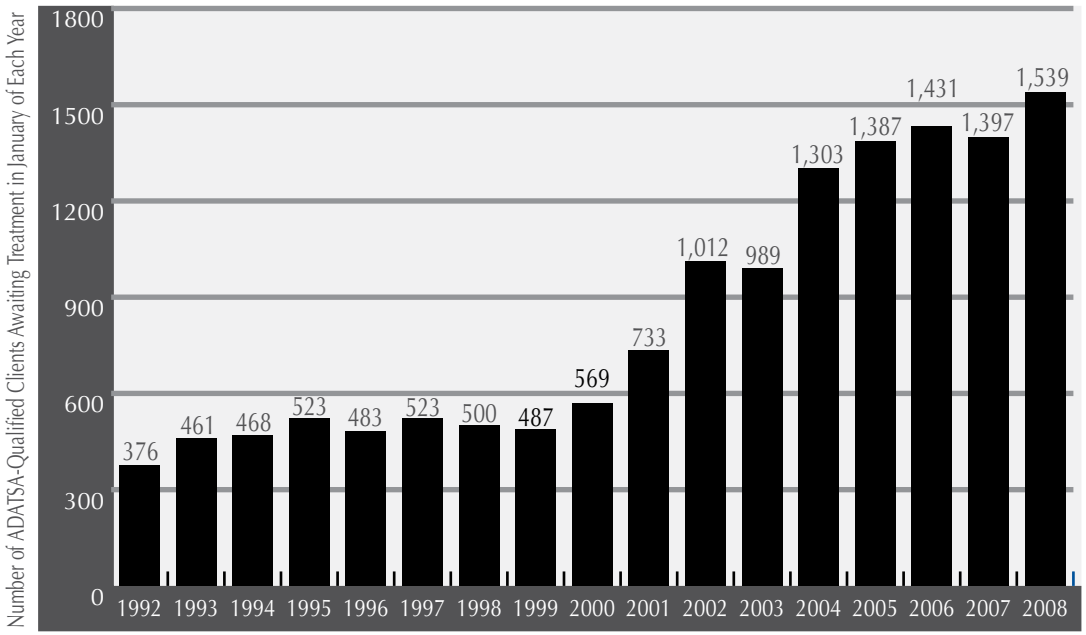
[1] Tanielian, T. & Jaycox, L., eds. *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.* Santa Monica, CA: RAND Center for Military Health Policy Research, 2008.

# Comparison of Veterans and Non-Veterans Admitted to DASA-Funded Treatment, SFY 2008

| | Veterans | Non-Veterans |
|---|---|---|
| Number of Individuals | 1,328 (4.4% of total) | 29,111 (95.6% of total) |
| Median Age | 46 | 33 |
| Gender | 93% male / 7% female | 60% male / 40% female |
| Race/Ethnicity | Caucasian - 73%; African American - 13%; Asian/Pacific Islander - 1%; American Indian - 6%; Multi-Racial/Other Race - 7%. Hispanic Origin - 5% | Caucasian - 67%; African American - 9%; Asian/Pacific Islander - 2%; American Indian - 9%; Multi-Racial/Other Race - 13%. Hispanic Origin - 11% |
| Employment Status | 18% employed full- or part-time | 20% employed full- or part-time |
| Primary Drug | Alcohol - 59%; Methamphetamine - 12%; Cocaine - 12% | Alcohol - 43%; Methamphetamine - 18%; Marijuana - 14% |
| % with Previous Admission | 48% | 46% |
| Criminal Justice Involvement | 59% arrested at least once in previous year | 63% arrested at least once in previous year |
| % with Children in the Home | 11% | 26% |
| Housing Status | 19% homeless* | 14% homeless* |
| % with Co-Occurring Disorders | 35% | 29% |
| Completion Rate (residential/outpatient) | 81% / 52% | 75% / 50% |

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

# The Waiting List in Washington State for Treatment Under the Alcohol and Drug Abuse Treatment and Support Act Has More than Quadrupled Since 1991.

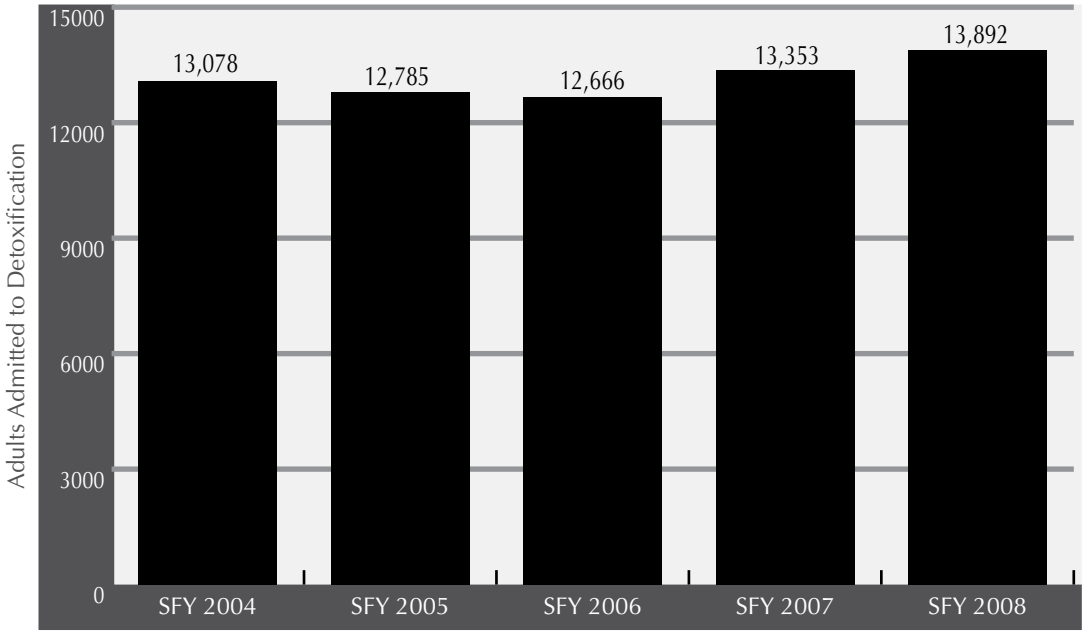



Source: Washington State Division of Alcohol and Substance Abuse, June 2009.

In 1989, the Washington State Legislature recognized in statute that, "alcoholism and drug addiction are treatable diseases, and that most persons with this illness can recover" (RCW 74.50.011). Under the Alcohol and Drug Abuse Treatment and Support Act (ADATSA), assessment, treatment, and support services are provided for individuals who are incapacitated from receipt of gainful employment and meet specific eligibility requirements.

The waiting list for ADATSA treatment services has more than quadrupled since 1992, and its growth is accelerating. Some of this growth is attributable to increased emphasis on treatment completion and retention, which has been shown to result in better outcomes. However, in SFY 2008, more than one-third (33.7%) of ADATSA clients already assessed as needing treatment were never admitted to treatment at all.

# The Number of Adult Admissions to DASA-Funded Detoxification Has Reached a New High.

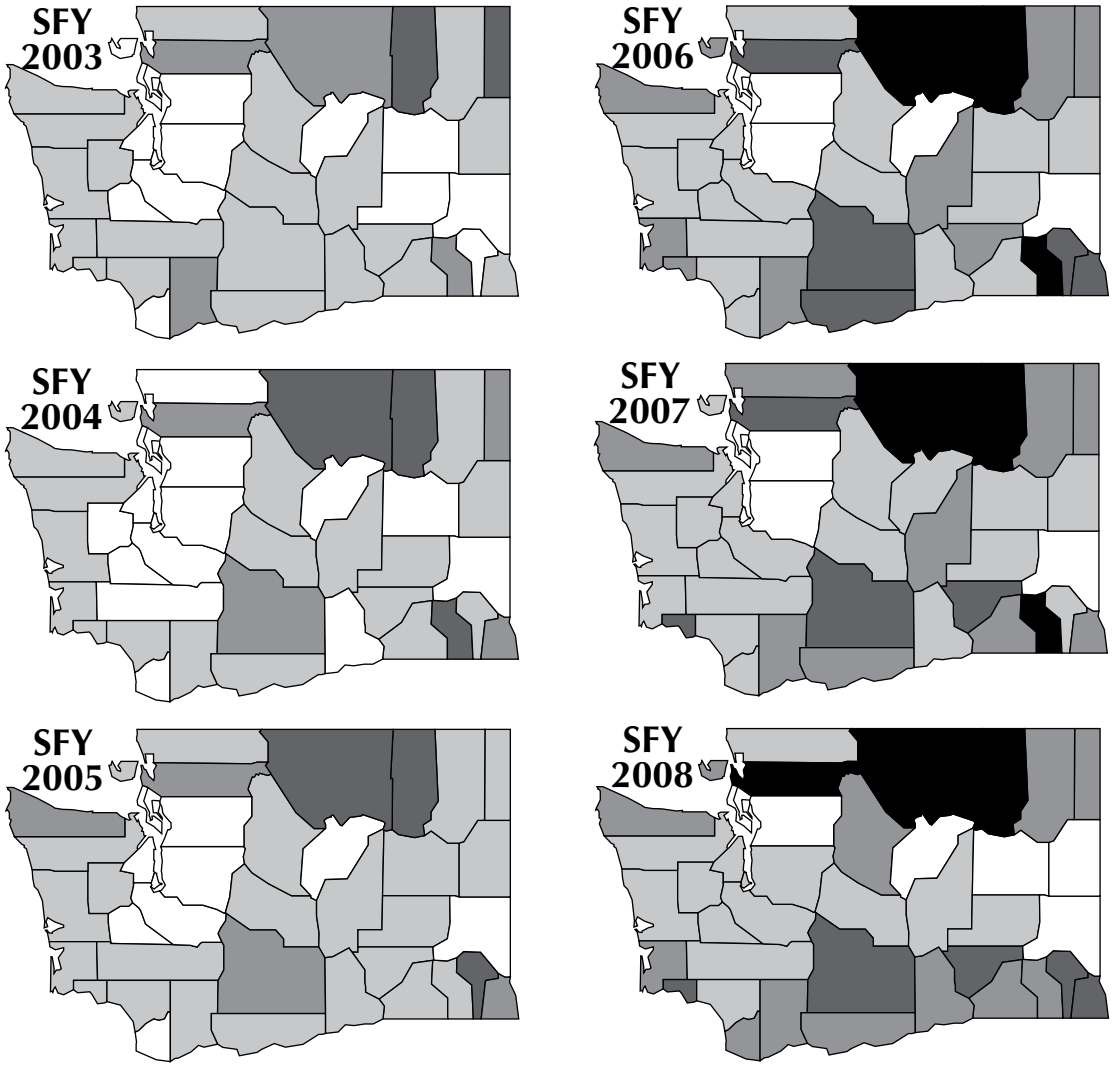



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

This graph indicates that the number of adult admissions to DASA-funded detoxification services has reached a new high. Detoxification for alcohol now accounts for 56.4% of all detoxification admissions. Binge drinking and heavy drinking among adults in Washington State are also at their highest points in a decade. Detoxification for methamphetamine fell by 22.3%, but increased by 30.8% for prescription-type opiates (non-heroin opiates and synthetics, oxycodone/hydrocodone, prescribed opiate substitute).

Detoxification is part of the array of services available to people in crisis, and is often a necessary precursor to chemical dependency treatment.

# Washington State Adult Treatment Admissions for Alcohol Per 100,000 in Population




Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

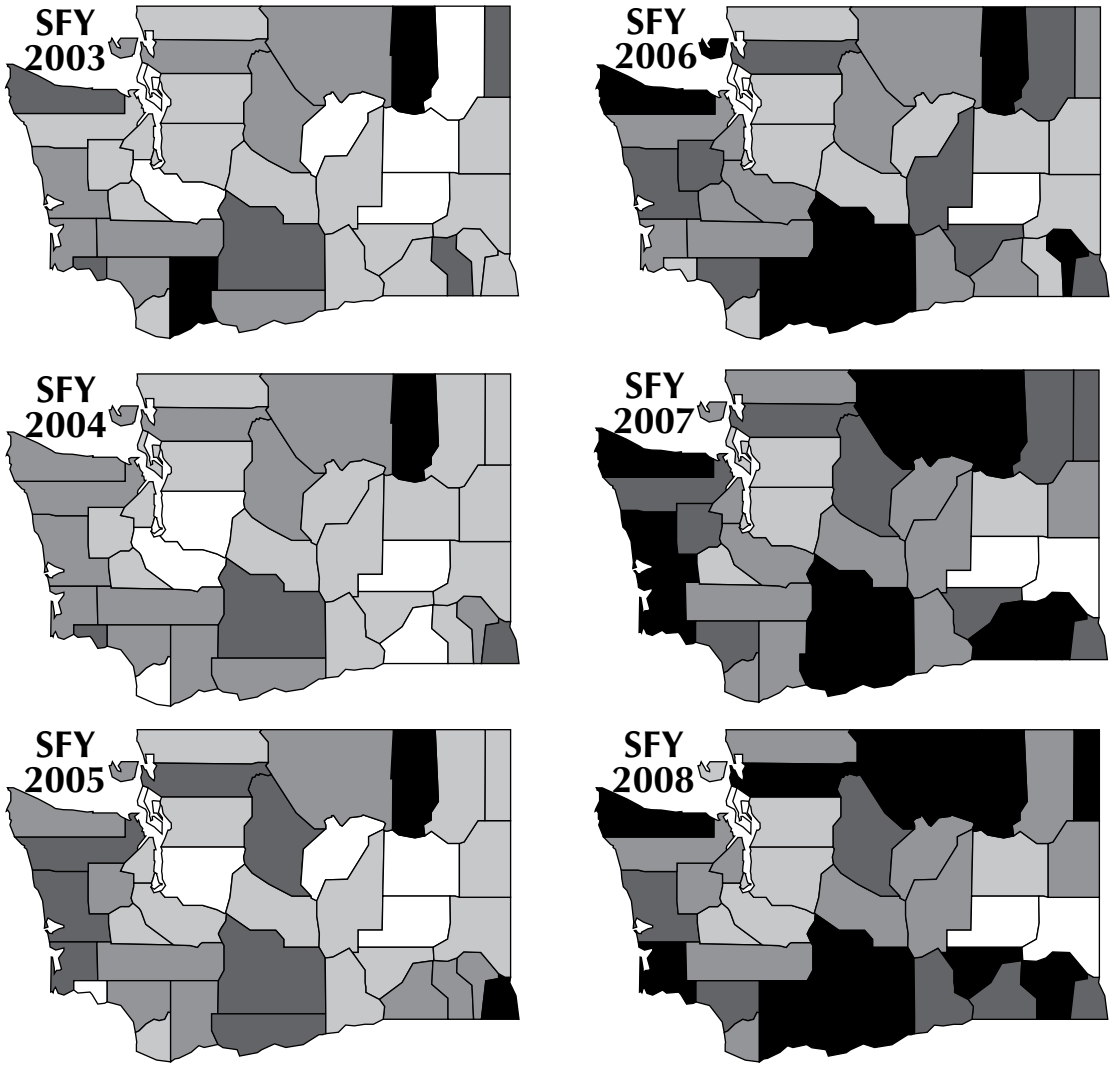
TARGET Treatment Admissions to Publicly Funded Treatment Service

# Washington State Adult Treatment Admissions* Primary Drug = Alcohol

| County Name | SFY 2003 | | SFY 2004 | | SFY 2005 | | SFY 2006 | | SFY 2007 | | SFY 2008 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Adams | 32 | 192.8 | 48 | 287.4 | 42 | 258.3 | 55 | 470.2 | 57 | 477.4 | 54 | 445.6 |
| Asotin | 55 | 267.0 | 118 | 570.0 | 130 | 653.9 | 143 | 889.9 | 96 | 590.2 | 133 | 811.4 |
| Benton | 404 | 266.5 | 367 | 236.6 | 394 | 260.4 | 461 | 399.3 | 548 | 466.7 | 649 | 542.5 |
| Chelan | 218 | 321.1 | 256 | 374.3 | 200 | 304.9 | 203 | 393.2 | 241 | 458.3 | 270 | 505.6 |
| Clallam | 270 | 413.5 | 280 | 424.9 | 378 | 595.1 | 346 | 641.5 | 392 | 717.3 | 407 | 735.0 |
| Clark | 551 | 148.0 | 583 | 152.1 | 681 | 182.3 | 739 | 251.4 | 890 | 293.7 | 1,064 | 342.6 |
| Columbia | 27 | 658.5 | 36 | 878.0 | 19 | 484.5 | 43 | 1,348.4 | 34 | 1,063.2 | 19 | 592.3 |
| Cowlitz | 358 | 377.2 | 341 | 357.8 | 243 | 266.6 | 261 | 360.2 | 217 | 295.5 | 302 | 405.1 |
| Douglas | 59 | 175.6 | 67 | 195.9 | 71 | 215.3 | 61 | 236.6 | 69 | 262.5 | 64 | 238.1 |
| Ferry | 81 | 1,109.6 | 58 | 794.5 | 56 | 776.3 | 58 | 1,031.0 | 69 | 1,214.3 | 67 | 1,151.7 |
| Franklin | 181 | 337.7 | 171 | 300.0 | 219 | 377.1 | 298 | 692.6 | 353 | 779.0 | 437 | 923.2 |
| Garfield | 2 | 83.3 | 7 | 291.7 | 19 | 833.8 | 17 | 935.5 | 6 | 336.1 | 16 | 912.3 |
| Grant | 237 | 307.4 | 277 | 353.8 | 282 | 373.7 | 361 | 643.1 | 301 | 522.1 | 274 | 462.0 |
| Grays Harbor | 221 | 321.2 | 243 | 351.2 | 208 | 312.3 | 203 | 379.6 | 217 | 402.3 | 242 | 446.6 |
| Island | 147 | 198.6 | 182 | 243.3 | 105 | 144.5 | 125 | 212.8 | 144 | 240.7 | 105 | 173.0 |
| Jefferson | 83 | 310.9 | 104 | 385.2 | 94 | 356.1 | 81 | 350.4 | 83 | 353.1 | 80 | 337.0 |
| King | 2,482 | 139.5 | 2,616 | 146.3 | 3,024 | 174.3 | 3,371 | 233.3 | 3,570 | 243.1 | 3,841 | 257.9 |
| Kitsap | 557 | 235.0 | 590 | 246.3 | 466 | 202.8 | 579 | 318.1 | 546 | 297.6 | 573 | 309.0 |
| Kittitas | 143 | 406.2 | 108 | 301.7 | 132 | 374.7 | 117 | 386.5 | 113 | 363.7 | 88 | 274.7 |
| Klickitat | 51 | 264.2 | 72 | 373.1 | 90 | 485.2 | 113 | 764.0 | 107 | 717.5 | 83 | 549.3 |
| Lewis | 184 | 261.4 | 169 | 239.0 | 189 | 277.1 | 231 | 421.6 | 179 | 320.4 | 169 | 299.1 |
| Lincoln | 22 | 217.8 | 32 | 313.7 | 35 | 367.7 | 23 | 294.6 | 33 | 417.2 | 13 | 162.2 |
| Mason | 180 | 358.6 | 137 | 269.7 | 155 | 311.6 | 168 | 405.3 | 170 | 397.7 | 192 | 434.3 |
| Okanogan | 289 | 729.8 | 328 | 828.3 | 371 | 985.3 | 355 | 1,203.4 | 336 | 1,135.2 | 363 | 1,213.0 |
| Pacific | 81 | 387.6 | 91 | 433.3 | 92 | 454.2 | 92 | 533.3 | 81 | 465.9 | 114 | 647.5 |
| Pend Oreille | 95 | 805.1 | 67 | 563.0 | 31 | 265.8 | 59 | 634.8 | 56 | 586.3 | 54 | 554.5 |
| Pierce | 1,185 | 161.5 | 1,327 | 178.4 | 1,387 | 192.0 | 1,724 | 300.2 | 1,517 | 257.8 | 1,577 | 262.4 |
| San Juan | 34 | 229.7 | 59 | 390.7 | 53 | 360.5 | 80 | 617.5 | 43 | 326.8 | 56 | 419.2 |
| Skagit | 567 | 531.4 | 798 | 733.5 | 757 | 717.5 | 836 | 981.7 | 863 | 991.4 | 1,002 | 1,126.2 |
| Skamania | 57 | 575.8 | 44 | 435.6 | 39 | 395.2 | 56 | 704.4 | 48 | 596.5 | 48 | 594.9 |
| Snohomish | 1,239 | 194.4 | 1,201 | 186.3 | 1,264 | 201.7 | 1,213 | 244.1 | 1,159 | 227.8 | 1,293 | 249.9 |
| Spokane | 1,290 | 301.0 | 1,236 | 286.1 | 1,320 | 317.5 | 1,369 | 407.1 | 1,501 | 438.0 | 1,691 | 483.8 |
| Stevens | 140 | 344.8 | 139 | 341.5 | 164 | 417.5 | 191 | 620.1 | 199 | 630.5 | 161 | 500.1 |
| Thurston | 421 | 196.0 | 506 | 231.6 | 465 | 216.1 | 518 | 294.3 | 618 | 340.1 | 698 | 371.8 |
| Wahkiakum | 27 | 710.5 | 18 | 473.7 | 11 | 293.3 | 16 | 523.4 | 25 | 794.8 | 25 | 772.8 |
| Walla Walla | 219 | 392.5 | 209 | 368.6 | 202 | 371.3 | 178 | 399.6 | 234 | 520.5 | 232 | 512.1 |
| Whatcom | 597 | 342.1 | 568 | 320.4 | 570 | 329.6 | 627 | 439.7 | 783 | 536.1 | 712 | 479.5 |
| Whitman | 82 | 200.0 | 61 | 146.3 | 95 | 231.2 | 86 | 241.4 | 72 | 202.2 | 52 | 144.8 |
| Yakima | 1,322 | 585.0 | 1,436 | 631.2 | 1,439 | 661.4 | 1,509 | 931.2 | 1,621 | 986.9 | 1,525 | 918.9 |
| **Total** | 14,190 | 232.7 | 14,950 | 226.1 | 15,492 | 259.0 | 16,966 | 351.5 | 17,591 | 357.3 | 18,745 | 374.2 |

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

# Washington State Adult Treatment Admissions for Marijuana Per 100,000 in Population




Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

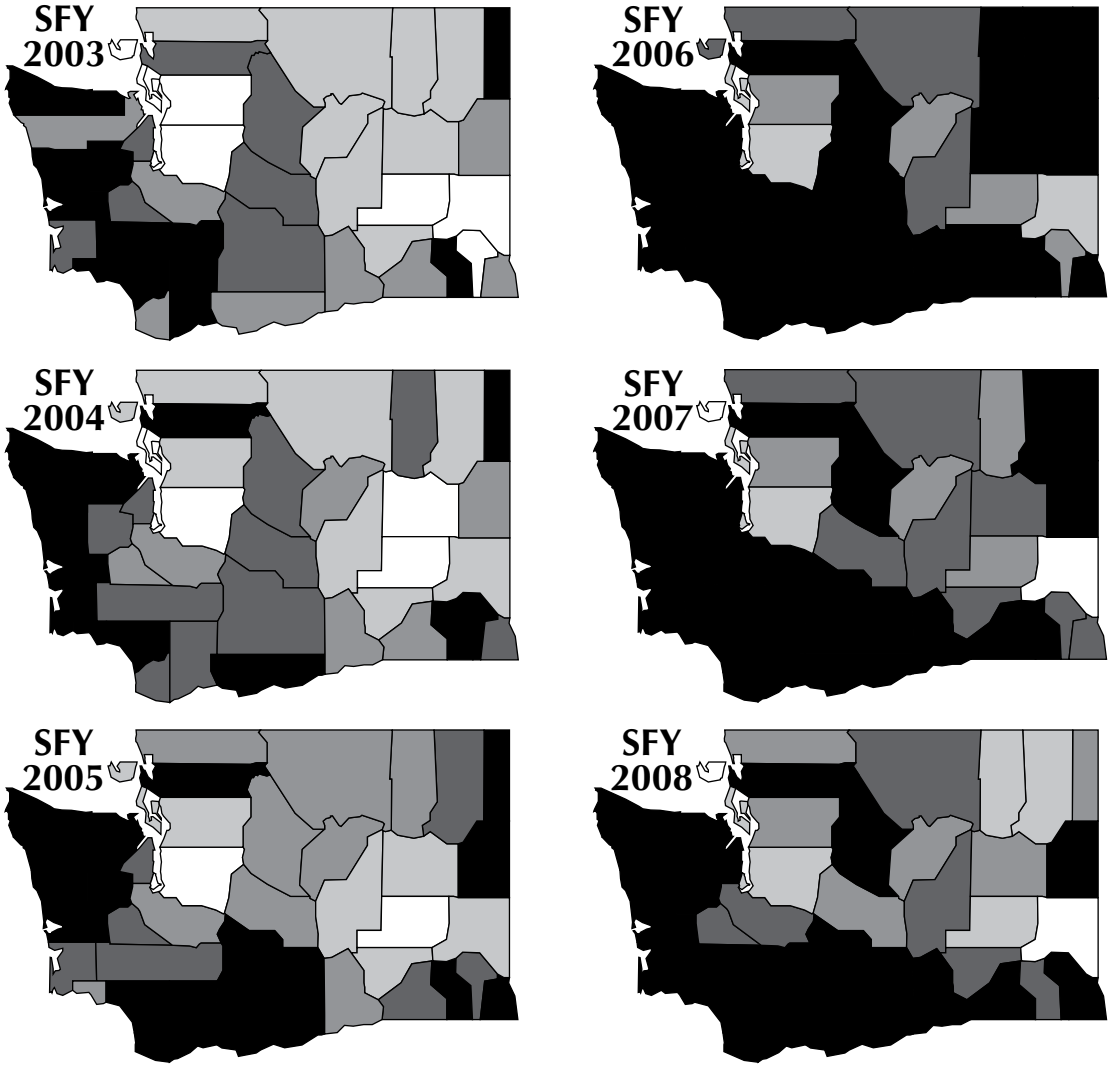
TARGET Treatment Admissions to Publicly Funded Treatment Service

# Washington State Adult Treatment Admissions* Primary Drug = Marijuana

| County Name | SFY 2003 | | SFY 2004 | | SFY 2005 | | SFY 2006 | | SFY 2007 | | SFY 2008 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Adams | 3 | 18.1 | 2 | 12.0 | 6 | 12.0 | 3 | 25.6 | 5 | 41.9 | 3 | 24.8 |
| Asotin | 15 | 72.8 | 34 | 164.3 | 49 | 246.5 | 30 | 186.7 | 29 | 178.3 | 27 | 164.7 |
| Benton | 114 | 75.2 | 99 | 63.8 | 133 | 87.9 | 152 | 131.7 | 141 | 120.1 | 218 | 182.2 |
| Chelan | 82 | 120.8 | 84 | 122.8 | 99 | 150.9 | 68 | 131.7 | 84 | 159.7 | 97 | 181.6 |
| Clallam | 107 | 163.9 | 91 | 138.1 | 91 | 143.3 | 137 | 254.0 | 130 | 237.9 | 134 | 242.0 |
| Clark | 195 | 52.4 | 177 | 46.2 | 220 | 58.9 | 260 | 88.5 | 314 | 103.6 | 328 | 105.6 |
| Columbia | 7 | 170.7 | 4 | 97.6 | 5 | 127.5 | 17 | 533.1 | 11 | 344.0 | 12 | 374.1 |
| Cowlitz | 113 | 119.1 | 129 | 135.4 | 123 | 134.9 | 139 | 191.8 | 125 | 170.2 | 140 | 187.8 |
| Douglas | 15 | 44.6 | 26 | 76.0 | 15 | 45.5 | 17 | 65.9 | 35 | 133.1 | 30 | 111.6 |
| Ferry | 16 | 219.2 | 16 | 219.2 | 20 | 277.2 | 35 | 622.2 | 25 | 440.0 | 24 | 412.6 |
| Franklin | 40 | 74.6 | 44 | 77.2 | 54 | 93.0 | 71 | 165.0 | 89 | 196.4 | 122 | 257.7 |
| Garfield | 2 | 83.3 | 3 | 125.0 | 3 | 131.6 | 4 | 220.1 | 4 | 224.1 | 5 | 285.1 |
| Grant | 52 | 67.4 | 69 | 88.1 | 66 | 87.5 | 99 | 176.4 | 66 | 114.5 | 62 | 104.5 |
| Grays Harbor | 87 | 126.5 | 83 | 119.9 | 130 | 195.2 | 93 | 173.9 | 116 | 215.1 | 93 | 171.6 |
| Island | 35 | 47.3 | 43 | 57.5 | 34 | 46.8 | 46 | 78.3 | 36 | 60.2 | 30 | 49.4 |
| Jefferson | 25 | 93.6 | 39 | 144.4 | 43 | 162.9 | 25 | 108.2 | 41 | 174.4 | 31 | 130.6 |
| King | 512 | 28.8 | 570 | 31.9 | 677 | 39.0 | 851 | 58.9 | 910 | 62.0 | 929 | 62.4 |
| Kitsap | 155 | 65.4 | 199 | 83.1 | 187 | 81.4 | 223 | 122.5 | 213 | 116.1 | 237 | 127.8 |
| Kittitas | 23 | 65.3 | 29 | 81.0 | 33 | 93.7 | 30 | 99.1 | 36 | 115.9 | 42 | 131.1 |
| Klickitat | 21 | 108.8 | 24 | 124.4 | 37 | 199.5 | 61 | 412.4 | 63 | 422.5 | 43 | 284.6 |
| Lewis | 82 | 116.5 | 75 | 106.1 | 76 | 111.4 | 61 | 111.3 | 77 | 137.8 | 71 | 125.7 |
| Lincoln | 5 | 49.5 | 8 | 78.4 | 3 | 31.5 | 5 | 64.0 | 6 | 75.9 | 5 | 62.4 |
| Mason | 50 | 99.6 | 42 | 82.7 | 65 | 130.7 | 81 | 195.4 | 70 | 163.8 | 58 | 131.2 |
| Okanogan | 52 | 131.3 | 52 | 131.3 | 54 | 143.4 | 44 | 149.2 | 85 | 287.2 | 68 | 227.2 |
| Pacific | 26 | 124.4 | 28 | 133.3 | 32 | 158.0 | 22 | 127.5 | 35 | 201.3 | 42 | 238.5 |
| Pend Oreille | 23 | 194.9 | 11 | 92.4 | 10 | 85.7 | 12 | 129.1 | 19 | 198.9 | 22 | 225.9 |
| Pierce | 442 | 60.2 | 514 | 69.1 | 606 | 83.9 | 728 | 126.8 | 682 | 115.9 | 547 | 91.0 |
| San Juan | 15 | 101.4 | 18 | 119.2 | 18 | 122.4 | 34 | 262.4 | 15 | 114.0 | 10 | 74.9 |
| Skagit | 129 | 120.9 | 146 | 134.2 | 162 | 153.5 | 166 | 194.9 | 148 | 170.0 | 191 | 214.7 |
| Skamania | 20 | 202.0 | 14 | 138.6 | 10 | 101.3 | 17 | 213.8 | 14 | 174.0 | 25 | 309.9 |
| Snohomish | 329 | 51.6 | 329 | 51.0 | 314 | 50.1 | 344 | 69.2 | 354 | 69.6 | 355 | 68.6 |
| Spokane | 250 | 58.3 | 277 | 64.1 | 305 | 73.4 | 329 | 97.8 | 411 | 119.9 | 430 | 123.0 |
| Stevens | 25 | 61.6 | 37 | 90.9 | 25 | 63.6 | 52 | 168.8 | 60 | 190.0 | 48 | 149.1 |
| Thurston | 189 | 88.0 | 167 | 76.4 | 171 | 79.5 | 204 | 115.9 | 174 | 95.8 | 184 | 98.0 |
| Wahkiakum | 7 | 184.2 | 6 | 157.9 | 1 | 26.7 | 3 | 98.1 | 9 | 286.1 | 7 | 216.4 |
| Walla Walla | 50 | 89.6 | 52 | 91.7 | 59 | 108.4 | 65 | 145.9 | 92 | 204.6 | 90 | 198.7 |
| Whatcom | 140 | 80.2 | 130 | 73.3 | 134 | 77.5 | 131 | 91.9 | 159 | 108.9 | 190 | 127.9 |
| Whitman | 22 | 53.7 | 22 | 52.8 | 24 | 58.4 | 30 | 84.2 | 12 | 33.7 | 16 | 44.6 |
| Yakima | 358 | 158.4 | 436 | 191.6 | 403 | 185.2 | 441 | 272.1 | 545 | 331.8 | 696 | 419.4 |
| **Total** | 3,833 | 62.9 | 4,129 | 66.9 | 4,497 | 75.2 | 5,130 | 106.3 | 5,440 | 110.5 | 5,662 | 113.0 |

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

# Washington State Adult Treatment Admissions for Methamphetamine Per 100,000 in Population




Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

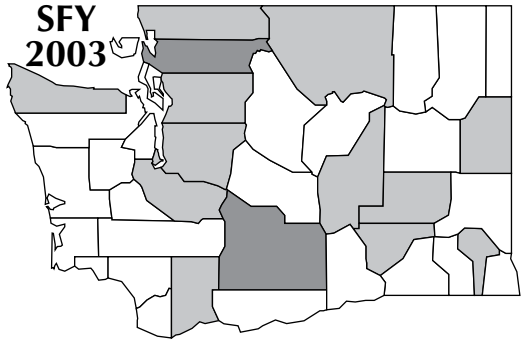
TARGET Treatment Admissions to Publicly Funded Treatment Service

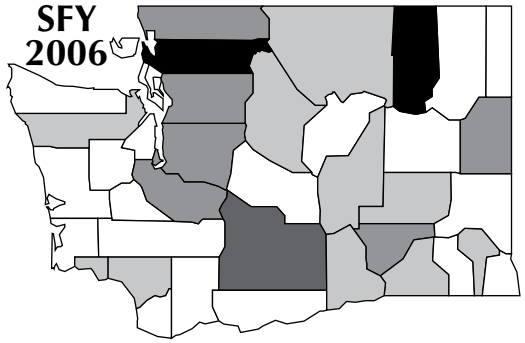
# Washington State Adult Treatment Admissions* Primary Drug = Methamphetamine

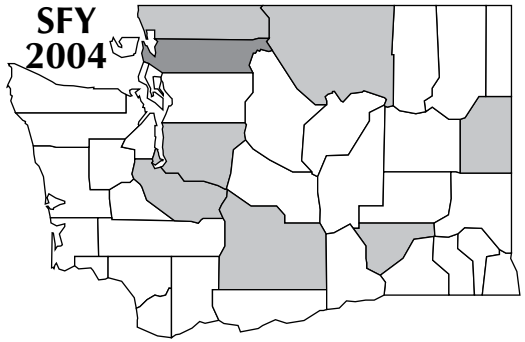
| County Name | SFY 2003 | | SFY 2004 | | SFY 2005 | | SFY 2006 | | SFY 2007 | | SFY 2008 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Adams | 1 | 6.0 | 7 | 41.9 | 4 | 24.6 | 12 | 102.6 | 12 | 100.5 | 10 | 82.5 |
| Asotin | 25 | 121.4 | 37 | 178.7 | 63 | 316.9 | 64 | 398.3 | 36 | 221.3 | 39 | 237.9 |
| Benton | 156 | 102.9 | 177 | 114.1 | 225 | 148.7 | 345 | 298.9 | 332 | 282.7 | 263 | 219.8 |
| Chelan | 105 | 154.6 | 109 | 159.4 | 93 | 141.8 | 136 | 263.5 | 134 | 254.8 | 117 | 219.1 |
| Clallam | 204 | 312.4 | 225 | 341.4 | 212 | 333.8 | 254 | 470.9 | 234 | 428.2 | 184 | 332.3 |
| Clark | 542 | 145.6 | 581 | 151.6 | 827 | 221.3 | 921 | 313.3 | 861 | 284.1 | 900 | 289.8 |
| Columbia | 12 | 292.7 | 10 | 243.9 | 8 | 204.0 | 8 | 250.9 | 10 | 312.7 | 6 | 187.0 |
| Cowlitz | 261 | 275.0 | 276 | 289.6 | 380 | 416.8 | 440 | 607.2 | 359 | 488.9 | 310 | 415.9 |
| Douglas | 31 | 92.3 | 38 | 111.1 | 37 | 112.2 | 26 | 100.9 | 39 | 148.4 | 35 | 130.2 |
| Ferry | 7 | 95.9 | 11 | 150.7 | 10 | 138.6 | 14 | 248.9 | 6 | 105.6 | 4 | 68.8 |
| Franklin | 48 | 89.6 | 48 | 84.2 | 50 | 86.1 | 106 | 246.4 | 87 | 192.0 | 89 | 188.0 |
| Garfield | 1 | 41.7 | 5 | 208.3 | 4 | 175.5 | 2 | 110.1 | 3 | 168.1 | 5 | 285.1 |
| Grant | 67 | 86.9 | 69 | 88.1 | 70 | 92.8 | 108 | 192.4 | 69 | 199.7 | 88 | 184.4 |
| Grays Harbor | 149 | 216.6 | 148 | 2213.9 | 197 | 295.7 | 241 | 450.6 | 237 | 439.4 | 193 | 356.2 |
| Island | 29 | 39.2 | 37 | 49.5 | 37 | 50.9 | 40 | 68.1 | 38 | 63.5 | 37 | 61.0 |
| Jefferson | 28 | 104.9 | 60 | 222.2 | 57 | 215.9 | 99 | 428.3 | 58 | 246.8 | 61 | 257.0 |
| King | 488 | 27.4 | 679 | 38.0 | 849 | 48.9 | 1,117 | 77.3 | 1,037 | 70.6 | 1,040 | 69.8 |
| Kitsap | 406 | 171.3 | 422 | 176.2 | 418 | 181.9 | 449 | 246.7 | 393 | 214.2 | 430 | 231.9 |
| Kittitas | 53 | 150.6 | 56 | 156.4 | 49 | 139.1 | 74 | 244.5 | 60 | 193.1 | 44 | 137.4 |
| Klickitat | 21 | 108.8 | 48 | 248.7 | 46 | 248.0 | 85 | 574.7 | 66 | 442.6 | 68 | 450.0 |
| Lewis | 180 | 255.7 | 138 | 195.2 | 132 | 193.5 | 157 | 286.5 | 149 | 266.7 | 131 | 231.9 |
| Lincoln | 7 | 69.3 | 3 | 29.4 | 9 | 94.5 | 25 | 320.2 | 15 | 189.6 | 11 | 137.2 |
| Mason | 116 | 231.1 | 88 | 173.2 | 141 | 283.4 | 141 | 340.2 | 130 | 304.1 | 145 | 328.0 |
| Okanogan | 23 | 58.1 | 35 | 88.4 | 49 | 130.1 | 50 | 169.5 | 47 | 158.8 | 48 | 160.4 |
| Pacific | 34 | 162.7 | 47 | 223.8 | 32 | 158.0 | 52 | 301.5 | 50 | 287.6 | 50 | 284.0 |
| Pend Oreille | 34 | 288.1 | 30 | 252.1 | 29 | 248.7 | 27 | 290.5 | 36 | 376.9 | 13 | 133.5 |
| Pierce | 889 | 121.2 | 870 | 116.9 | 1,078 | 149.2 | 1,475 | 256.8 | 1,193 | 202.7 | 997 | 165.9 |
| San Juan | 6 | 40.5 | 8 | 53.0 | 9 | 61.2 | 22 | 169.8 | 6 | 45.6 | 5 | 37.4 |
| Skagit | 190 | 178.1 | 240 | 220.6 | 320 | 303.3 | 377 | 442.7 | 273 | 313.6 | 270 | 303.5 |
| Skamania | 28 | 282.8 | 20 | 198.0 | 32 | 324.2 | 52 | 654.0 | 37 | 459.8 | 29 | 359.4 |
| Snohomish | 370 | 58.0 | 414 | 64.2 | 518 | 82.6 | 679 | 136.7 | 680 | 133.7 | 642 | 124.1 |
| Spokane | 557 | 130.0 | 637 | 147.5 | 841 | 202.3 | 922 | 274.2 | 840 | 245.1 | 990 | 283.3 |
| Stevens | 31 | 76.4 | 28 | 68.8 | 64 | 162.9 | 77 | 250.0 | 88 | 278.8 | 31 | 96.3 |
| Thurston | 327 | 152.2 | 306 | 140.0 | 346 | 160.8 | 353 | 200.6 | 434 | 238.9 | 352 | 187.5 |
| Wahkiakum | 12 | 315.8 | 8 | 210.5 | 4 | 106.7 | 20 | 654.2 | 17 | 540.5 | 7 | 216.4 |
| Walla Walla | 70 | 125.4 | 75 | 132.3 | 85 | 156.2 | 98 | 220.0 | 119 | 264.7 | 93 | 205.3 |
| Whatcom | 117 | 67.0 | 114 | 64.3 | 182 | 105.2 | 229 | 160.6 | 241 | 165.0 | 221 | 148.8 |
| Whitman | 10 | 24.4 | 23 | 55.2 | 24 | 58.4 | 30 | 84.2 | 13 | 36.5 | 11 | 30.6 |
| Yakima | 359 | 158.8 | 385 | 169.2 | 444 | 204.1 | 694 | 428.2 | 783 | 476.7 | 683 | 411.6 |
| **Total** | 5,994 | 98.3 | 6,512 | 105.6 | 7,975 | 133.3 | 10,021 | 207.6 | 9,222 | 187.3 | 8,652 | 172.7 |

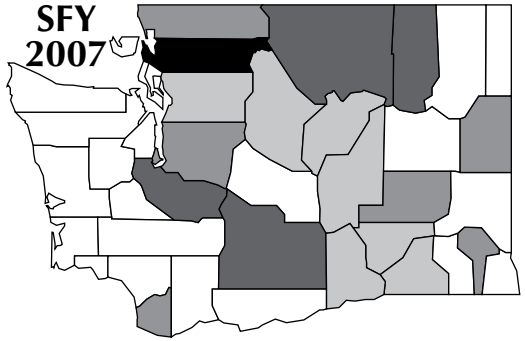
*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

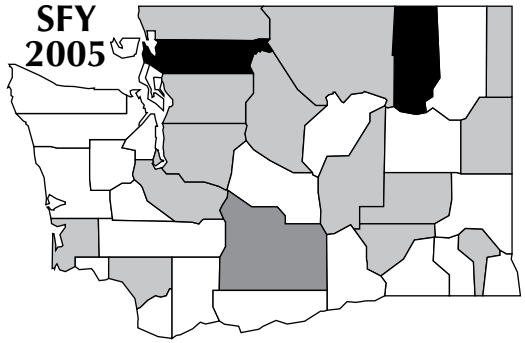
# Washington State Adult Treatment Admissions for Cocaine Per 100,000 in Population

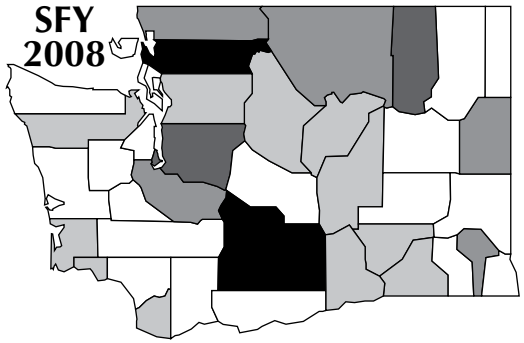


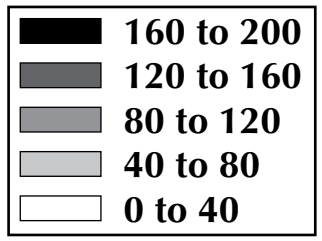




Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

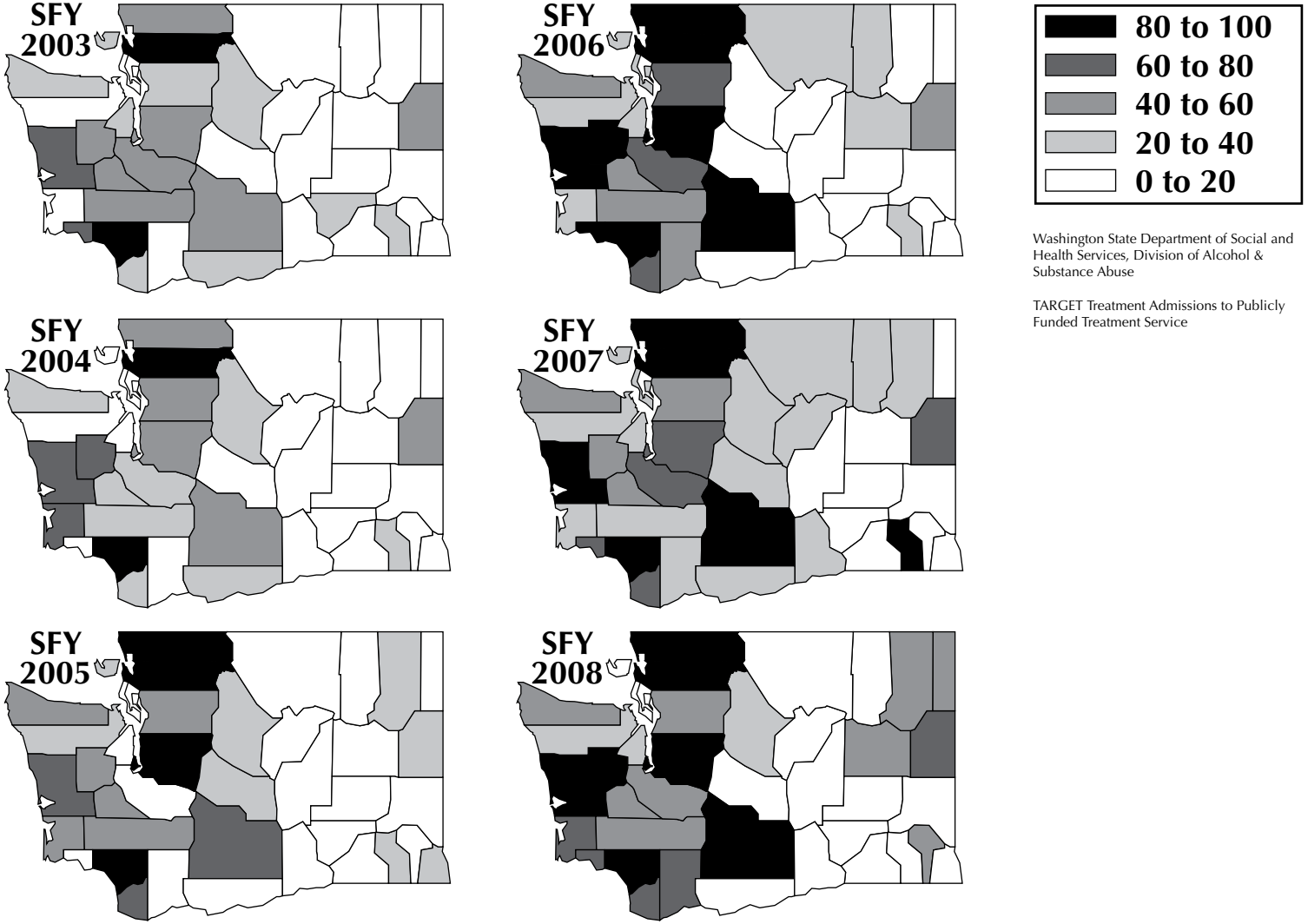
TARGET Treatment Admissions to Publicly Funded Treatment Service

# Washington State Adult Treatment Admissions* Primary Drug = Cocaine

| County Name | SFY 2003 | | SFY 2004 | | SFY 2005 | | SFY 2006 | | SFY 2007 | | SFY 2008 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Adams | 8 | 48.2 | 2 | 12.0 | 9 | 55.4 | 8 | 68.4 | 12 | 100.5 | 2 | 16.5 |
| Asotin | 0 | 0.0 | 0 | 0.0 | 4 | 20.1 | 1 | 6.2 | 6 | 36.9 | 0 | 0.0 |
| Benton | 37 | 24.4 | 41 | 26.4 | 44 | 29.1 | 68 | 58.9 | 62 | 52.8 | 69 | 57.7 |
| Chelan | 27 | 39.8 | 26 | 38.0 | 27 | 41.2 | 35 | 67.8 | 31 | 59.0 | 42 | 78.6 |
| Clallam | 32 | 49.0 | 20 | 30.3 | 16 | 25.2 | 16 | 29.7 | 18 | 32.9 | 13 | 23.5 |
| Clark | 88 | 23.6 | 113 | 29.5 | 116 | 31.0 | 109 | 37.1 | 130 | 42.9 | 173 | 55.7 |
| Columbia | 1 | 24.4 | 0 | 0.0 | 1 | 25.5 | 1 | 31.4 | 0 | 0.0 | 1 | 31.2 |
| Cowlitz | 33 | 34.8 | 35 | 36.7 | 41 | 45.0 | 33 | 45.5 | 29 | 39.5 | 21 | 28.2 |
| Douglas | 8 | 23.8 | 11 | 32.2 | 13 | 39.4 | 4 | 15.5 | 15 | 57.1 | 17 | 63.2 |
| Ferry | 1 | 13.7 | 2 | 27.4 | 13 | 180.2 | 27 | 480.0 | 8 | 140.8 | 8 | 137.5 |
| Franklin | 30 | 56.0 | 38 | 66.7 | 34 | 58.5 | 51 | 118.5 | 36 | 79.4 | 33 | 69.7 |
| Garfield | 1 | 41.7 | 0 | 0.0 | 1 | 43.9 | 1 | 55.0 | 2 | 112.0 | 2 | 114.0 |
| Grant | 38 | 49.3 | 33 | 42.1 | 34 | 45.1 | 39 | 69.5 | 27 | 46.8 | 41 | 69.1 |
| Grays Harbor | 16 | 23.3 | 19 | 27.5 | 11 | 16.5 | 12 | 22.4 | 17 | 31.5 | 14 | 25.8 |
| Island | 13 | 17.6 | 22 | 29.4 | 15 | 20.6 | 16 | 27.2 | 12 | 20.1 | 8 | 13.2 |
| Jefferson | 7 | 26.2 | 4 | 14.8 | 4 | 15.2 | 14 | 60.6 | 6 | 25.5 | 10 | 42.1 |
| King | 895 | 50.3 | 960 | 53.7 | 1,337 | 77.1 | 1,537 | 106.4 | 1,733 | 118.0 | 1,931 | 129.7 |
| Kitsap | 69 | 29.1 | 98 | 40.9 | 56 | 24.4 | 59 | 32.4 | 68 | 37.1 | 69 | 37.2 |
| Kittitas | 9 | 25.6 | 3 | 8.4 | 0 | 0.0 | 4 | 13.2 | 11 | 35.4 | 5 | 15.6 |
| Klickitat | 1 | 5.2 | 2 | 10.4 | 1 | 5.4 | 2 | 13.5 | 2 | 13.4 | 1 | 6.6 |
| Lewis | 4 | 5.7 | 9 | 12.7 | 3 | 4.4 | 8 | 14.6 | 2 | 3.6 | 12 | 21.2 |
| Lincoln | 0 | 0.0 | 3 | 29.4 | 0 | 0.0 | 2 | 25.6 | 1 | 12.6 | 1 | 12.5 |
| Mason | 9 | 17.9 | 18 | 35.4 | 11 | 22.1 | 13 | 31.4 | 13 | 30.4 | 9 | 20.4 |
| Okanogan | 24 | 60.6 | 22 | 55.6 | 29 | 77.0 | 22 | 74.6 | 38 | 128.4 | 25 | 83.5 |
| Pacific | 6 | 28.7 | 5 | 23.8 | 9 | 44.4 | 3 | 17.4 | 6 | 34.5 | 8 | 45.4 |
| Pend Oreille | 3 | 25.4 | 0 | 0.0 | 6 | 51.4 | 3 | 32.3 | 3 | 31.4 | 2 | 20.5 |
| Pierce | 418 | 57.0 | 463 | 62.2 | 483 | 66.9 | 681 | 118.6 | 729 | 123.9 | 593 | 98.7 |
| San Juan | 3 | 20.3 | 3 | 19.9 | 3 | 20.4 | 4 | 30.9 | 2 | 15.2 | 4 | 29.9 |
| Skagit | 116 | 108.7 | 163 | 149.8 | 198 | 187.7 | 199 | 233.7 | 162 | 186.1 | 183 | 205.7 |
| Skamania | 5 | 50.5 | 4 | 39.6 | 1 | 10.1 | 0 | 0.0 | 0 | 0.0 | 1 | 12.4 |
| Snohomish | 273 | 42.8 | 273 | 42.3 | 288 | 45.9 | 413 | 83.1 | 323 | 63.5 | 357 | 69.0 |
| Spokane | 316 | 73.7 | 305 | 70.6 | 262 | 63.0 | 340 | 101.1 | 372 | 108.5 | 403 | 115.3 |
| Stevens | 12 | 29.6 | 3 | 7.4 | 13 | 33.1 | 7 | 22.7 | 11 | 34.8 | 11 | 34.2 |
| Thurston | 42 | 19.6 | 39 | 17.8 | 47 | 21.8 | 29 | 16.5 | 65 | 35.8 | 38 | 20.2 |
| Wahkiakum | 1 | 26.3 | 0 | 0.0 | 0 | 0.0 | 2 | 65.4 | 1 | 31.8 | 2 | 61.8 |
| Walla Walla | 12 | 21.5 | 21 | 37.0 | 12 | 22.1 | 19 | 42.7 | 18 | 40.0 | 25 | 55.2 |
| Whatcom | 119 | 68.2 | 90 | 50.8 | 112 | 64.8 | 148 | 103.8 | 163 | 111.6 | 149 | 100.3 |
| Whitman | 7 | 17.1 | 4 | 9.6 | 7 | 17.0 | 4 | 11.2 | 0 | 0.0 | 3 | 8.4 |
| Yakima | 229 | 101.3 | 221 | 97.1 | 188 | 86.4 | 200 | 123.4 | 237 | 144.3 | 275 | 165.7 |
| **Total** | 2,913 | 47.8 | 3,075 | 49.9 | 3,449 | 57.7 | 4,134 | 71.0 | 4,371 | 88.8 | 4,561 | 91.0 |

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

# Washington State Adult Treatment Admissions for Heroin Per 100,000 in Population




Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

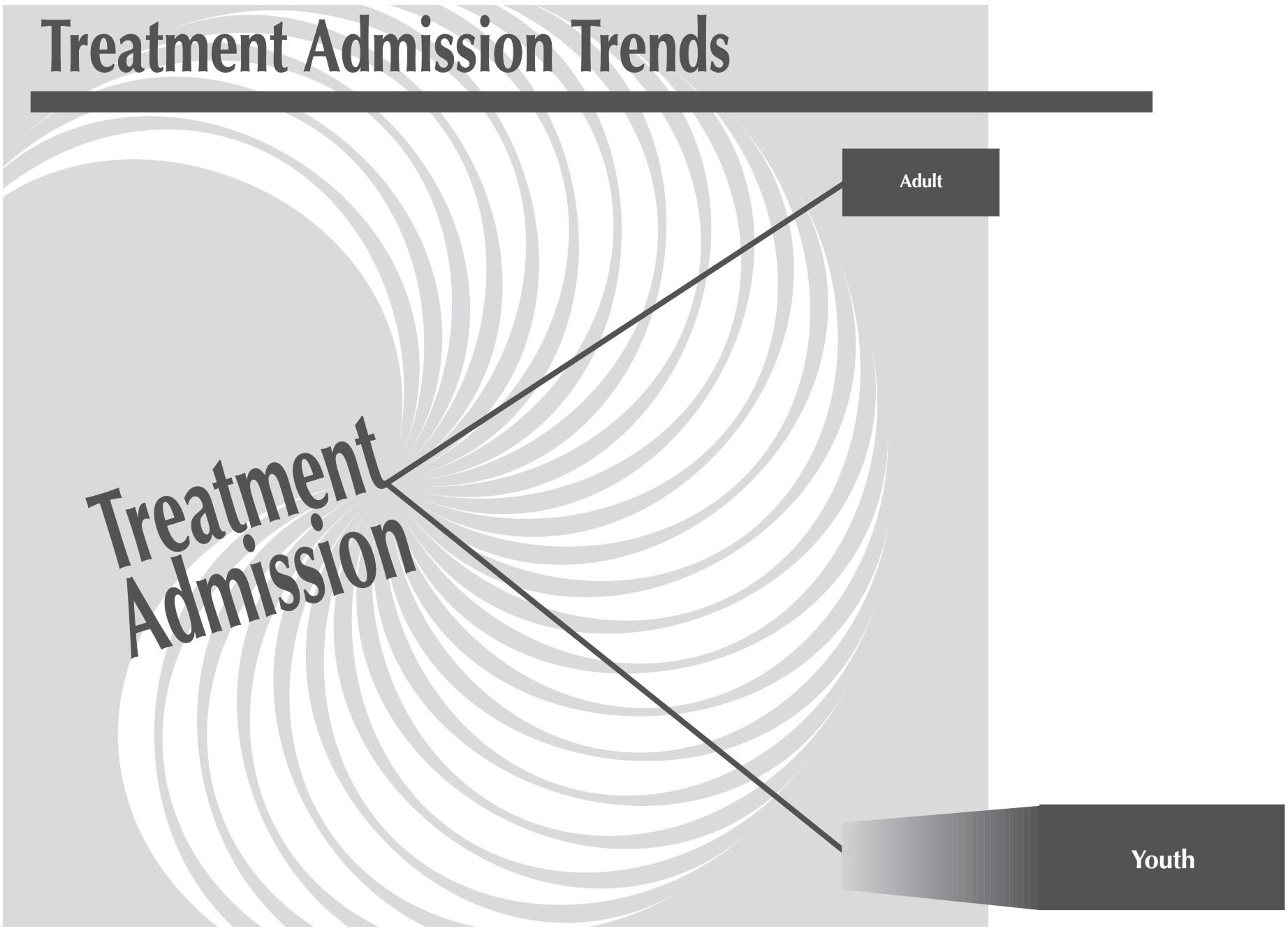
TARGET Treatment Admissions to Publicly Funded Treatment Service

# Washington State Adult Treatment Admissions* Primary Drug = Heroin

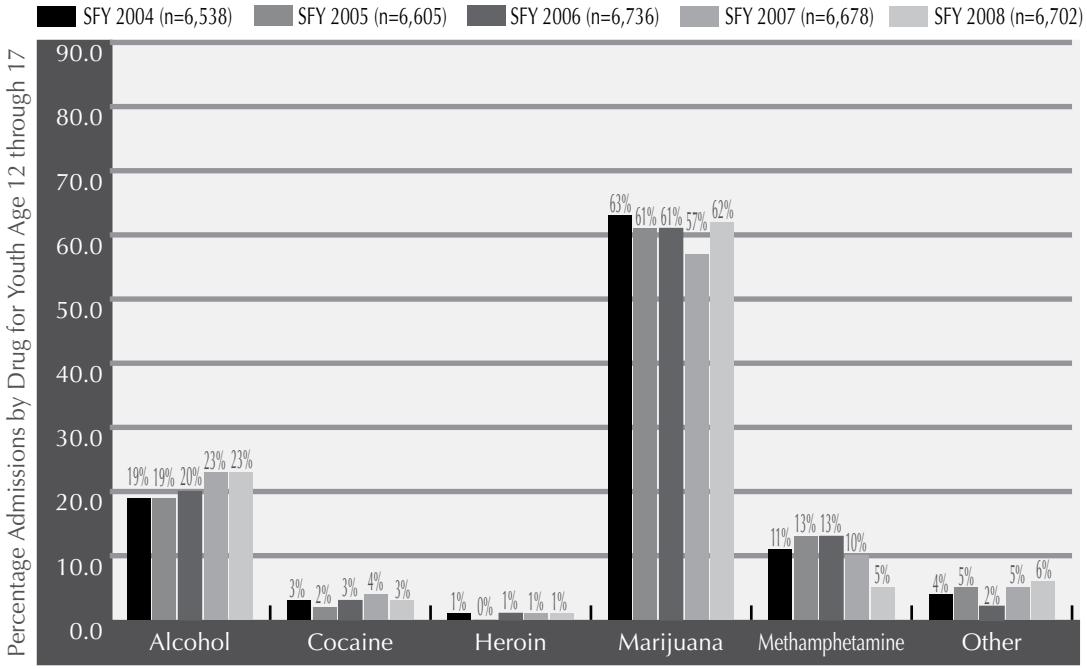
| County Name | SFY 2003 | | SFY 2004 | | SFY 2005 | | SFY 2006 | | SFY 2007 | | SFY 2008 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Adams | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 8.5 | 0 | 0.0 | 0 | 0.0 |
| Asotin | 1 | 4.9 | 1 | 4.8 | 5 | 25.1 | 3 | 18.7 | 1 | 6.1 | 1 | 6.1 |
| Benton | 22 | 14.5 | 18 | 11.6 | 21 | 13.9 | 19 | 16.5 | 29 | 24.7 | 18 | 15.0 |
| Chelan | 15 | 22.1 | 19 | 27.8 | 19 | 29.0 | 5 | 9.7 | 15 | 28.5 | 11 | 20.6 |
| Clallam | 16 | 24.5 | 22 | 33.4 | 27 | 42.5 | 30 | 55.6 | 22 | 40.3 | 28 | 50.6 |
| Clark | 112 | 30.1 | 96 | 25.0 | 244 | 65.3 | 200 | 68.0 | 187 | 61.7 | 226 | 72.8 |
| Columbia | 1 | 24.4 | 1 | 24.4 | 1 | 25.5 | 1 | 31.4 | 4 | 125.1 | 0 | 0.0 |
| Cowlitz | 91 | 95.9 | 90 | 94.4 | 97 | 106.4 | 81 | 111.8 | 116 | 158.0 | 155 | 207.9 |
| Douglas | 4 | 11.9 | 0 | 0.0 | 0 | 0.0 | 4 | 15.5 | 7 | 26.6 | 0 | 0.0 |
| Ferry | 0 | 0.0 | 1 | 13.7 | 0 | 0.0 | 2 | 35.6 | 2 | 35.2 | 0 | 0.0 |
| Franklin | 14 | 26.1 | 10 | 17.5 | 5 | 8.6 | 6 | 13.9 | 3 | 6.6 | 4 | 8.5 |
| Garfield | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 57.0 |
| Grant | 12 | 15.6 | 3 | 3.8 | 6 | 8.0 | 6 | 10.7 | 4 | 6.9 | 4 | 6.7 |
| Grays Harbor | 55 | 79.9 | 45 | 65.0 | 49 | 73.6 | 45 | 84.1 | 52 | 96.4 | 52 | 96.0 |
| Island | 2 | 2.7 | 7 | 9.4 | 7 | 9.6 | 12 | 20.4 | 19 | 31.8 | 11 | 18.1 |
| Jefferson | 2 | 7.5 | 3 | 11.1 | 8 | 30.3 | 5 | 21.6 | 7 | 29.8 | 7 | 29.5 |
| King | 783 | 44.0 | 984 | 55.0 | 1,844 | 106.3 | 1,485 | 102.8 | 1,171 | 79.7 | 1,299 | 87.2 |
| Kitsap | 56 | 23.6 | 43 | 18.0 | 34 | 14.8 | 46 | 25.3 | 41 | 22.3 | 61 | 32.9 |
| Kittitas | 2 | 5.7 | 0 | 0.0 | 0 | 0.0 | 1 | 3.3 | 8 | 25.7 | 0 | 0.0 |
| Klickitat | 6 | 31.1 | 7 | 36.3 | 0 | 0.0 | 1 | 6.8 | 3 | 20.1 | 2 | 13.2 |
| Lewis | 36 | 51.1 | 28 | 39.6 | 39 | 57.2 | 22 | 40.2 | 16 | 28.6 | 26 | 46.0 |
| Lincoln | 1 | 9.9 | 2 | 19.6 | 0 | 0.0 | 3 | 38.4 | 0 | 0.0 | 4 | 49.9 |
| Mason | 32 | 63.7 | 32 | 63.0 | 29 | 58.3 | 35 | 84.4 | 19 | 44.5 | 40 | 90.5 |
| Okanogan | 3 | 7.6 | 6 | 15.2 | 2 | 5.3 | 6 | 20.3 | 8 | 27.0 | 3 | 10.0 |
| Pacific | 4 | 19.1 | 15 | 71.4 | 11 | 54.3 | 5 | 29.0 | 5 | 28.8 | 13 | 73.8 |
| Pend Oreille | 2 | 16.9 | 1 | 8.4 | 0 | 0.0 | 0 | 0.0 | 1 | 10.5 | 4 | 41.1 |
| Pierce | 321 | 43.8 | 264 | 35.5 | 267 | 37.0 | 383 | 66.7 | 364 | 61.9 | 281 | 46.8 |
| San Juan | 3 | 20.3 | 1 | 6.6 | 5 | 34.0 | 5 | 38.6 | 4 | 30.4 | 1 | 7.5 |
| Skagit | 93 | 87.2 | 152 | 139.7 | 141 | 133.6 | 148 | 173.8 | 137 | 157.4 | 157 | 176.5 |
| Skamania | 0 | 0.0 | 2 | 19.8 | 1 | 10.1 | 4 | 50.3 | 3 | 37.3 | 6 | 74.4 |
| Snohomish | 142 | 22.3 | 282 | 47.1 | 308 | 49.1 | 331 | 66.6 | 249 | 48.9 | 259 | 50.1 |
| Spokane | 203 | 47.4 | 178 | 41.2 | 148 | 35.6 | 173 | 51.4 | 229 | 66.8 | 271 | 77.5 |
| Stevens | 1 | 2.5 | 1 | 2.5 | 8 | 20.4 | 5 | 16.2 | 8 | 25.3 | 14 | 43.5 |
| Thurston | 120 | 55.9 | 78 | 35.7 | 124 | 57.6 | 72 | 40.9 | 85 | 46.8 | 109 | 58.1 |
| Wahkiakum | 3 | 78.9 | 0 | 0.0 | 0 | 0.0 | 5 | 163.6 | 2 | 63.6 | 2 | 61.8 |
| Walla Walla | 9 | 16.1 | 3 | 5.3 | 3 | 5.5 | 4 | 9.0 | 8 | 17.8 | 6 | 13.2 |
| Whatcom | 93 | 53.3 | 87 | 49.1 | 143 | 82.7 | 147 | 103.1 | 152 | 104.1 | 205 | 138.1 |
| Whitman | 8 | 19.5 | 1 | 2.4 | 0 | 0.0 | 0 | 0.0 | 3 | 8.4 | 7 | 19.5 |
| Yakima | 122 | 54.0 | 134 | 58.9 | 116 | 62.1 | 148 | 91.3 | 153 | 93.1 | 151 | 91.0 |
| **Total** | 2,390 | 39.2 | 2,617 | 42.4 | 3,712 | 62.1 | 3,449 | 71.5 | 3,137 | 63.7 | 3,439 | 68.6 |

*Admissions rate per 100,000 population. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

# Treatment Admission Trends



# Marijuana is the Most Frequently Cited Drug of Abuse in Youth Admissions to DASA-Funded Treatment.*




Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2009.

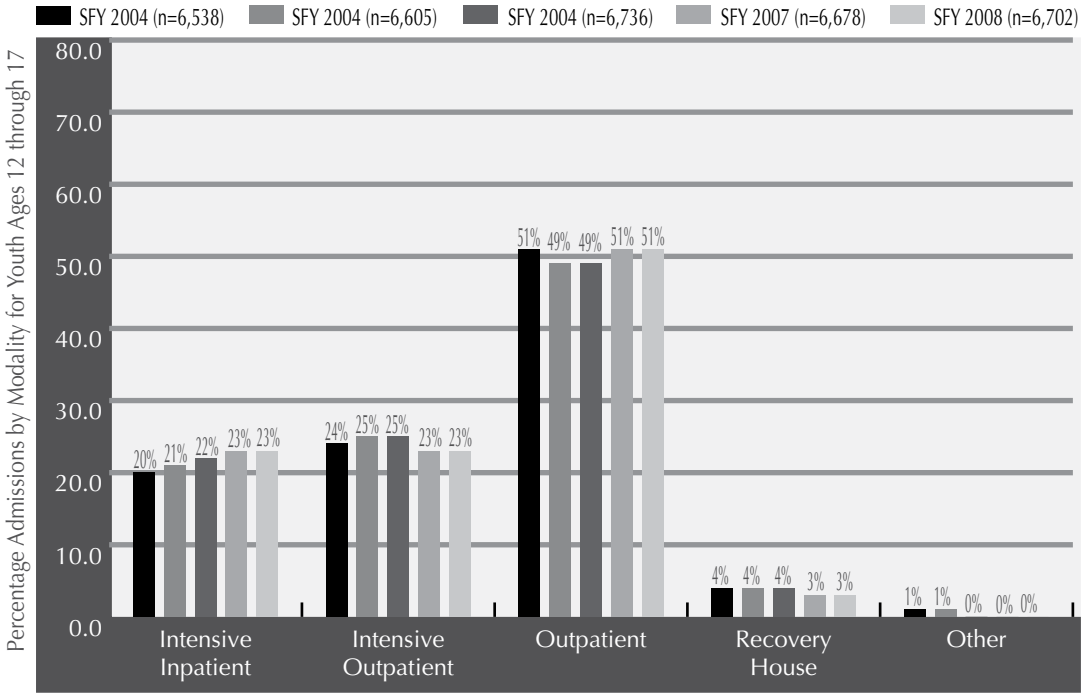
This graph indicates that the majority of youth admissions to DASA-funded treatment are for marijuana. Admissions for alcohol increased by 24.5% between SFY 2004 and SFY 2008. There was a precipitous fall in admissions for methamphetamine abuse, from 872 in SFY 2006 to 352 in SFY 2008, representing a 59.6% decline.

Of special note is the increase in youth admissions where the primary drug of abuse was a prescription-type opiate (non-heroin opiates and synthetics, oxycodone/hydrocodone, and prescribed opiate substitute). There were 148 such admissions in SFY 2008, up from 104 in SFY 2007, and 49 in SFY 2004.

Note: Data may include multiple admissions for a single individual over the course of a year.

** Excludes detoxification and transitional housing.*

# The Majority of Youth Admissions to DASA-Funded Chemical Dependency Treatment are for Outpatient Services.*




Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2009.

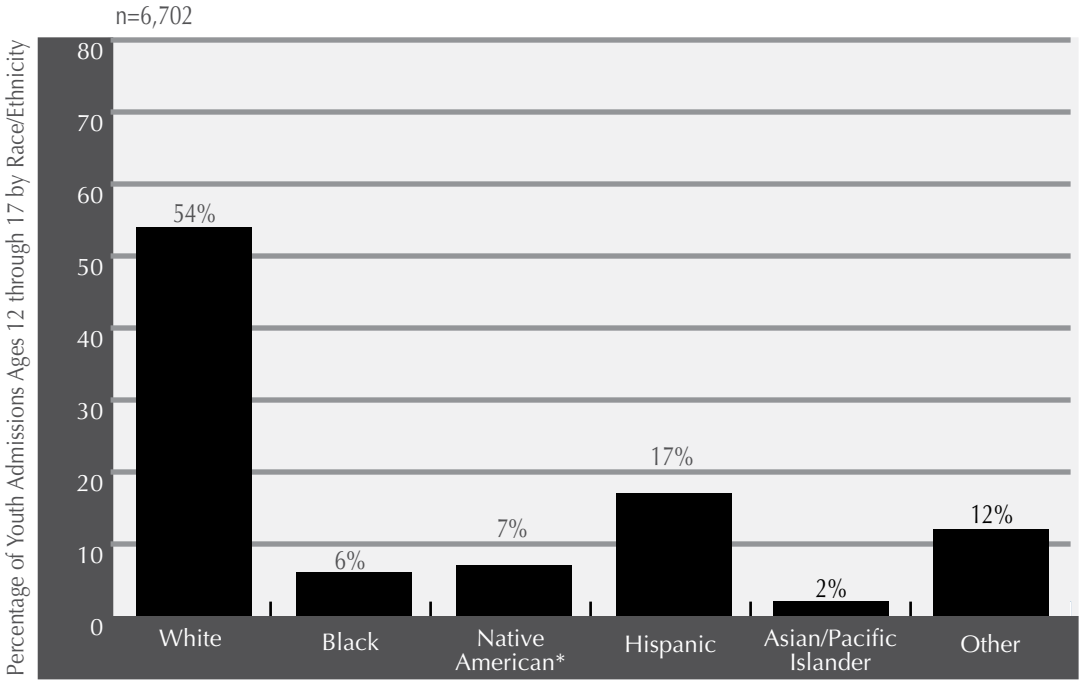
Almost three-quarters of youth admissions to DASA-funded chemical dependency treatment are for outpatient and intensive outpatient services.

DASA offers two levels of intensive inpatient treatment. Level I is for youth with a primary chemical dependency diagnosis, but who require less clinical supervision and behavior management, and are less likely to have co-occurring mental health disorders. Level II is for youth who have both a chemical dependency and mental health diagnosis, and require concurrent management of both conditions. Patients have often had prior trauma, experienced extreme family dysfunction, and may pose a risk to themselves or others.

Note: Data may include multiple admissions for a single individual over the course of a year. "Other" includes group care enhancement, recovery house, long-term residential, methadone, and treatment services for those with co-occurring disorders.

** Excludes detoxification and transitional housing.*

# Racial and Ethnic Minorities Comprise 46% of Youth Admissions to DASA-Funded Chemical Dependency Treatment Services.



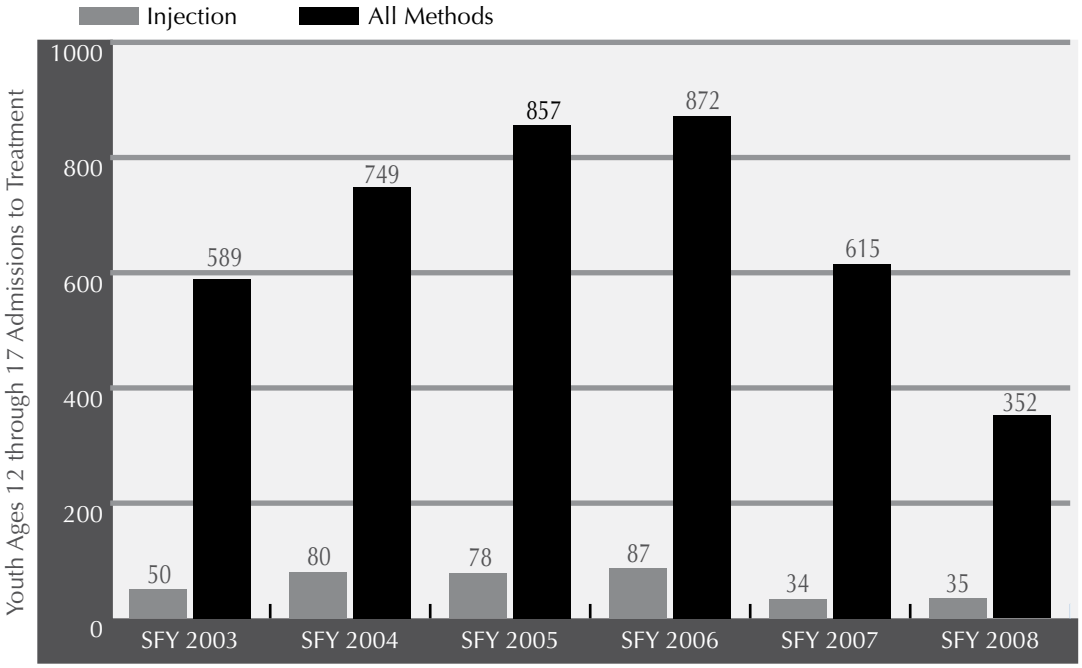

Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2009.

This graph indicates that racial/ethnic minorities comprised approximately 46% of youth admissions to DASA-funded chemical dependency treatment in SFY 2008. Percentages of youth from different groups receiving DASA-funded treatment vary across modalities.

** Includes Eskimo/Alaskan Native/Aleut*

NEW/CHANGING TREND

# DASA-Funded Youth Treatment Admissions for Methamphetamine Have Declined Precipitously.



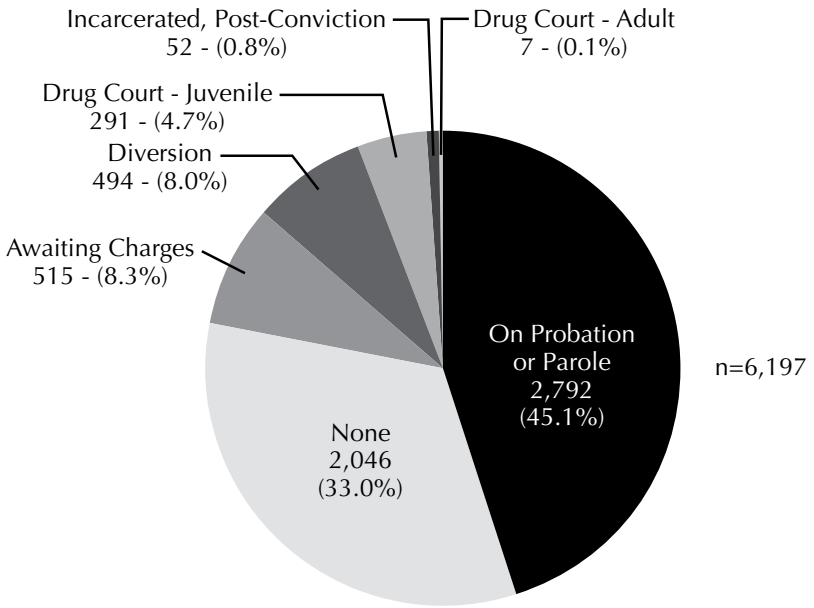

Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

DASA-funded youth admissions for methamphetamine abuse have dropped substantially, by 59.6% between SFY 2006 and 2008, and is at its lowest point in this decade. The number of youth who entered treatment having injected methamphetamine declined by more than half, and is at its lowest point in this decade.

At the same time as methamphetamine-related youth admissions are decreasing, treatment admissions for abuse of prescription-type opiates (non-heroin opiates and synthetics, oxycodone/hydrocodone, prescribed opiate substitute) have increased substantially, from 34 in SFY 2004 to 148 in SFY 2008.

Note: Data exclude detoxification and transitional housing, private-pay, and Department of Corrections admission; includes total unduplicated admissions within counties.

# Two-Thirds of Youth Admitted to Chemical Dependency Treatment in SFY 2008 were Involved with the Criminal Justice System at Time of Admission.

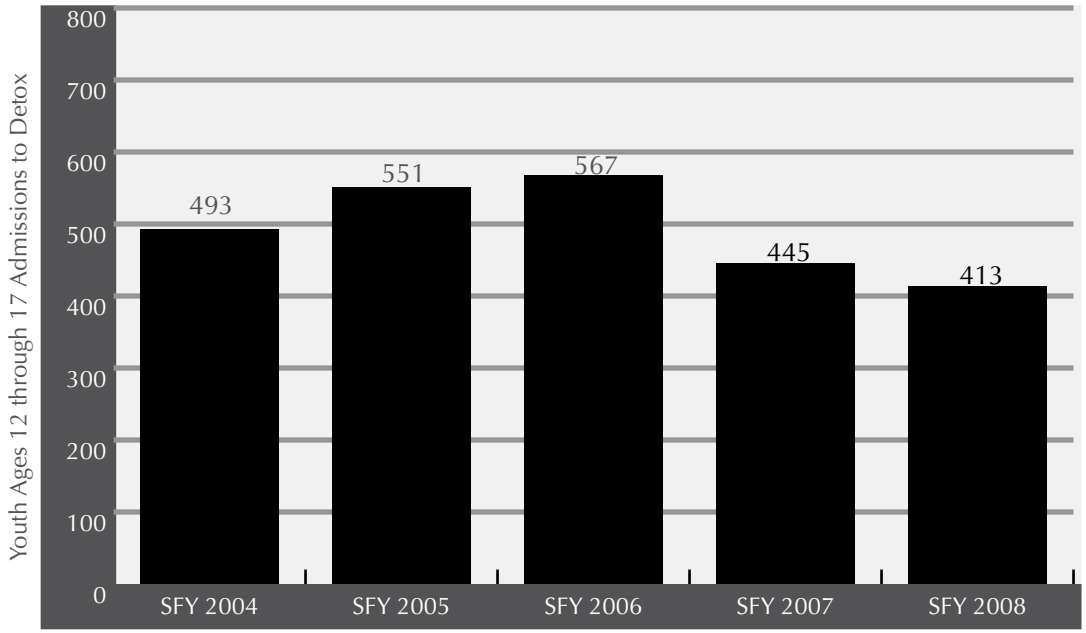



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2009.

Involvement with the criminal justice system is often what precipitates youth in crisis toward seeking treatment for their substance-abuse related problems. There are significant declines in both misdemeanor (30%) and felony convictions (56%) among Washington State youth in the 18 months following chemical dependency treatment.[1]

[1] Luchansky, B., et al. "Treatment Readmissions and Criminal Recidivism in Youth Following Participation in Chemical Dependency Treatment." *Journal of Addictive Diseases 25*(1), 2006.

# The Number of Youth Admissions to DASA-Funded Detoxification Declined in SFY 2008.

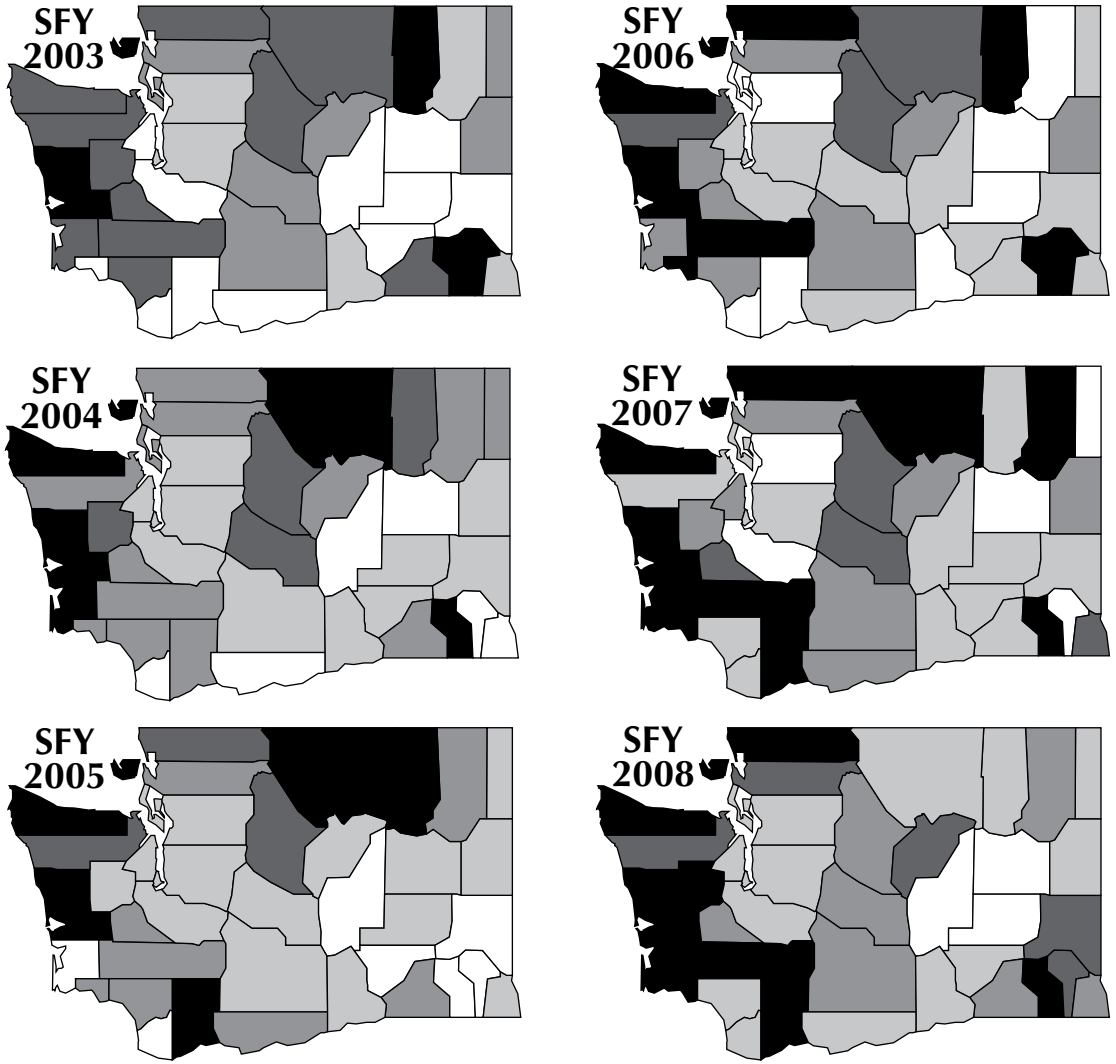



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

This graph indicates that the number of youth admissions to DASA-funded detoxification services fell in SFY 2008. A plurality (39.7%) of DASA-funded youth admissions to detoxification services are for marijuana.

Detoxification is part of the array of services available to youth in crisis, and is often a necessary precursor to chemical dependency treatment.

# Washington State Youth Treatment Admissions for Alcohol Per 100,000 in Population




Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

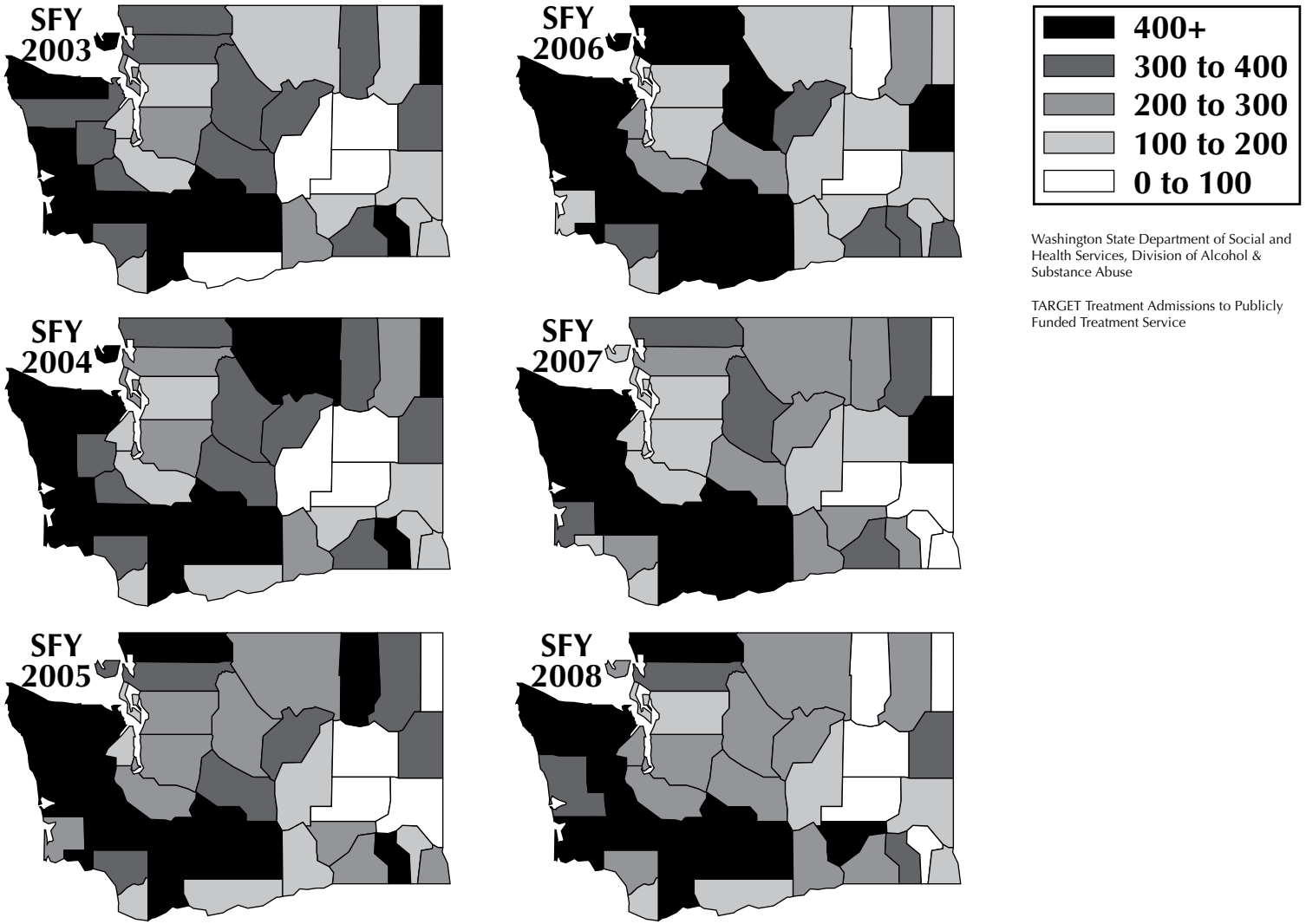
TARGET Treatment Admissions to Publicly Funded Treatment Service

# Washington State Youth Treatment Admissions * Primary Drug = Alcohol

| County Name | SFY 2003 | | SFY 2004 | | SFY 2005 | | SFY 2006 | | SFY 2007 | | SFY 2008 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Adams | 2 | 36.3 | 4 | 72.9 | 3 | 54.1 | 0 | 0.0 | 4 | 70.7 | 1 | 17.6 |
| Asotin | 4 | 78.9 | 2 | 39.8 | 5 | 99.4 | 5 | 99.4 | 9 | 178.8 | 6 | 119.8 |
| Benton | 32 | 73.1 | 25 | 56.4 | 24 | 53.6 | 22 | 48.7 | 37 | 81.4 | 28 | 61.0 |
| Chelan | 35 | 190.2 | 31 | 169.1 | 34 | 184.9 | 32 | 173.2 | 28 | 150.4 | 22 | 117.7 |
| Clallam | 21 | 151.8 | 40 | 290.5 | 63 | 456.6 | 39 | 281.4 | 62 | 447.5 | 45 | 325.5 |
| Clark | 37 | 35.7 | 26 | 24.6 | 52 | 48.6 | 46 | 42.0 | 66 | 59.0 | 72 | 63.3 |
| Columbia | 10 | 1,060.0 | 6 | 644.7 | 0 | 0.0 | 3 | 329.3 | 3 | 332.6 | 5 | 560.5 |
| Cowlitz | 47 | 191.2 | 27 | 110.7 | 36 | 148.0 | 27 | 111.0 | 15 | 61.5 | 20 | 81.8 |
| Douglas | 12 | 125.0 | 14 | 144.8 | 9 | 92.6 | 12 | 120.9 | 13 | 129.9 | 19 | 187.7 |
| Ferry | 5 | 264.9 | 3 | 161.1 | 4 | 214.2 | 4 | 213.4 | 1 | 53.5 | 1 | 53.1 |
| Franklin | 7 | 38.7 | 10 | 52.5 | 8 | 39.8 | 11 | 52.0 | 20 | 90.5 | 20 | 87.5 |
| Garfield | 2 | 332.4 | 0 | 0.0 | 0 | 0.0 | 2 | 343.2 | 0 | 0.0 | 1 | 183.1 |
| Grant | 10 | 41.7 | 11 | 45.6 | 10 | 41.3 | 16 | 65.4 | 15 | 60.4 | 9 | 35.6 |
| Grays Harbor | 53 | 310.7 | 53 | 312.7 | 44 | 259.9 | 64 | 378.2 | 52 | 308.4 | 56 | 335.0 |
| Island | 20 | 109.7 | 23 | 126.2 | 15 | 81.8 | 9 | 48.8 | 11 | 59.3 | 15 | 80.6 |
| Jefferson | 8 | 159.7 | 6 | 120.3 | 8 | 159.0 | 9 | 177.0 | 4 | 78.5 | 8 | 158.0 |
| King | 263 | 67.7 | 285 | 73.8 | 226 | 58.3 | 260 | 66.6 | 295 | 75.1 | 341 | 86.4 |
| Kitsap | 30 | 48.8 | 33 | 53.7 | 44 | 72.0 | 39 | 63.5 | 62 | 101.1 | 44 | 71.7 |
| Kittitas | 9 | 129.6 | 11 | 158.0 | 6 | 85.2 | 6 | 84.2 | 11 | 152.2 | 10 | 135.8 |
| Klickitat | 2 | 39.7 | 2 | 40.2 | 5 | 100.4 | 4 | 79.9 | 5 | 100.2 | 4 | 80.2 |
| Lewis | 30 | 166.3 | 21 | 117.3 | 25 | 139.3 | 38 | 209.8 | 72 | 394.8 | 47 | 258.2 |
| Lincoln | 0 | 0.0 | 1 | 40.9 | 2 | 83.6 | 1 | 41.8 | 1 | 41.8 | 0 | 0.0 |
| Mason | 21 | 184.4 | 18 | 158.2 | 8 | 69.6 | 17 | 145.9 | 17 | 143.4 | 41 | 339.2 |
| Okanogan | 18 | 170.1 | 26 | 248.8 | 24 | 232.1 | 16 | 155.3 | 28 | 274.4 | 9 | 88.5 |
| Pacific | 7 | 162.8 | 14 | 329.1 | 2 | 47.0 | 6 | 141.2 | 9 | 213.5 | 13 | 310.0 |
| Pend Oreille | 3 | 100.4 | 3 | 100.9 | 3 | 99.6 | 2 | 66.5 | 0 | 0.0 | 2 | 65.3 |
| Pierce | 85 | 43.9 | 100 | 51.4 | 102 | 52.0 | 107 | 53.7 | 99 | 49.0 | 126 | 61.6 |
| San Juan | 7 | 259.0 | 11 | 405.5 | 8 | 291.7 | 6 | 218.7 | 9 | 328.1 | 9 | 328.5 |
| Skagit | 32 | 117.9 | 28 | 102.3 | 38 | 137.5 | 35 | 125.2 | 38 | 134.5 | 45 | 157.7 |
| Skamania | 1 | 39.3 | 3 | 116.8 | 7 | 269.7 | 0 | 0.0 | 12 | 452.3 | 6 | 228.0 |
| Snohomish | 92 | 54.1 | 89 | 52.2 | 108 | 62.8 | 72 | 41.2 | 88 | 49.6 | 117 | 65.3 |
| Spokane | 117 | 109.6 | 93 | 87.4 | 86 | 80.7 | 148 | 137.6 | 126 | 116.1 | 77 | 70.3 |
| Stevens | 8 | 71.2 | 14 | 125.8 | 12 | 107.6 | 4 | 35.4 | 24 | 209.9 | 13 | 113.0 |
| Thurston | 83 | 157.6 | 55 | 103.8 | 67 | 124.4 | 60 | 108.9 | 91 | 161,6 | 79 | 137.2 |
| Wahkiakum | 0 | 0.0 | 1 | 118.9 | 1 | 117.3 | 3 | 355.9 | 2 | 234.0 | 4 | 462.5 |
| Walla Walla | 25 | 188.6 | 18 | 135.3 | 14 | 104.6 | 12 | 89.8 | 11 | 82.4 | 16 | 120.3 |
| Whatcom | 61 | 150.1 | 56 | 137.2 | 74 | 179.4 | 92 | 220.7 | 87 | 205.9 | 96 | 225.9 |
| Whitman | 3 | 42.2 | 6 | 84.3 | 3 | 41.8 | 7 | 97.6 | 7 | 98.7 | 12 | 169.3 |
| Yakima | 75 | 107.5 | 69 | 99.3 | 68 | 97.8 | 84 | 120.4 | 78 | 111.5 | 70 | 100.1 |
| **Total** | 1,277 | 84.0 | 1,238 | 81.3 | 1,248 | 81.5 | 1,320 | 85.2 | 1,512 | 96.6 | 1,509 | 95.6 |

* Admissions rate per 100,000 population ages 0-18. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

# Washington State Youth Treatment Admissions for Marijuana Per 100,000 in Population




Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

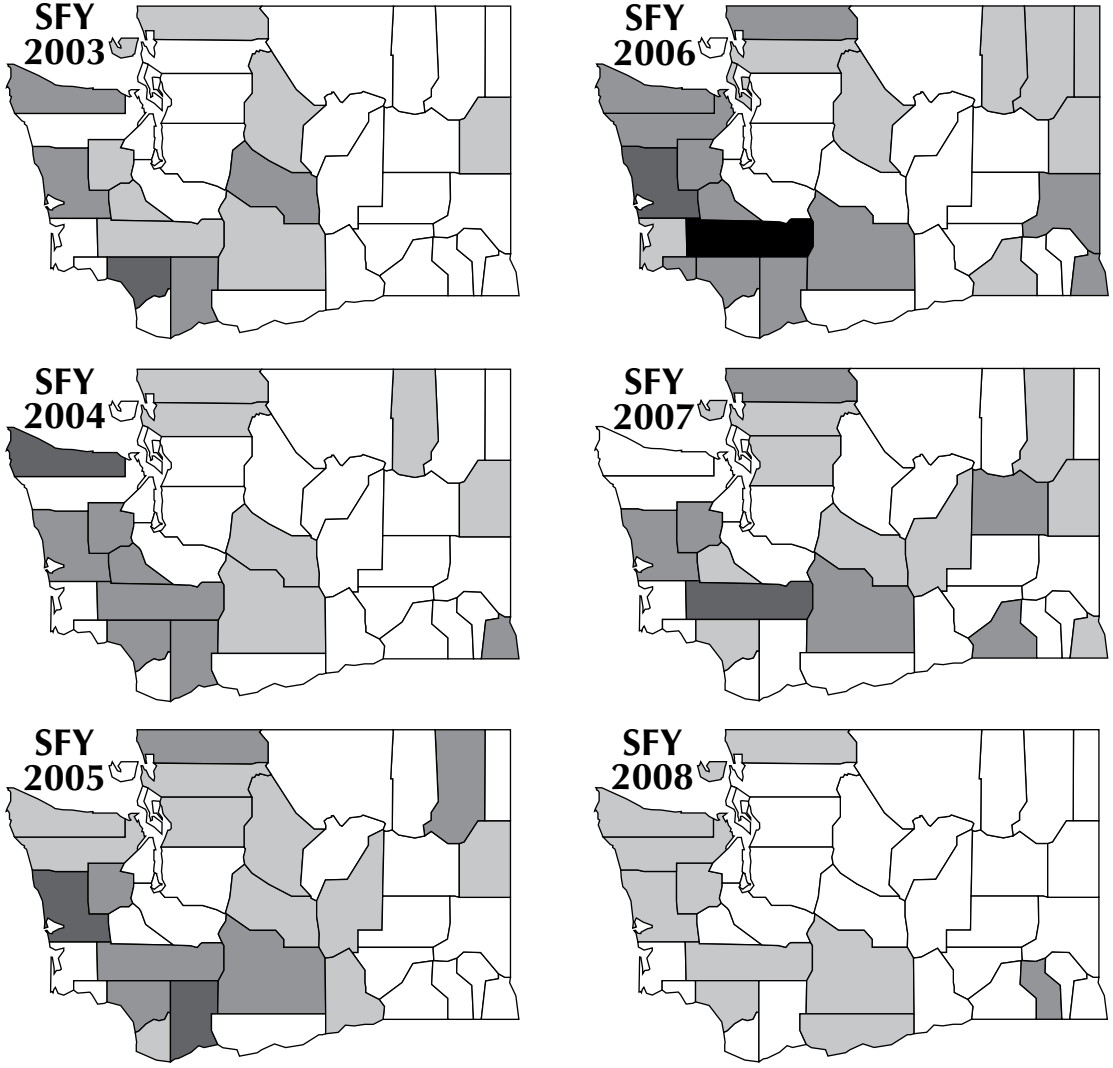
TARGET Treatment Admissions to Publicly Funded Treatment Service

# Washington State Youth Treatment Admissions * Primary Drug = Marijuana

| County Name | SFY 2003 | | SFY 2004 | | SFY 2005 | | SFY 2006 | | SFY 2007 | | SFY 2008 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Adams | 2 | 36.3 | 2 | 36.4 | 0 | 0.0 | 1 | 17.8 | 4 | 70.7 | 1 | 17.6 |
| Asotin | 6 | 118.4 | 12 | 119.3 | 14 | 278.5 | 17 | 337.9 | 3 | 59.6 | 6 | 119.8 |
| Benton | 92 | 210.3 | 79 | 207.7 | 81 | 180.9 | 89 | 197.1 | 114 | 250.7 | 117 | 255.1 |
| Chelan | 71 | 385.8 | 52 | 387.2 | 46 | 250.2 | 83 | 449.2 | 59 | 316.9 | 50 | 267.5 |
| Clallam | 83 | 599.8 | 112 | 602.7 | 99 | 717.6 | 100 | 721.4 | 99 | 714.6 | 118 | 853.6 |
| Clark | 166 | 160.1 | 167 | 157.1 | 189 | 176.5 | 182 | 166.1 | 196 | 175.1 | 185 | 162.7 |
| Columbia | 5 | 530.0 | 2 | 537.2 | 5 | 543.4 | 3 | 329.3 | 2 | 221.7 | 3 | 336.3 |
| Cowlitz | 92 | 374.3 | 125 | 377.1 | 75 | 308.4 | 75 | 308.2 | 61 | 250.2 | 50 | 204.4 |
| Douglas | 29 | 302.1 | 30 | 300.0 | 36 | 370.3 | 33 | 332.6 | 25 | 249.7 | 30 | 296.4 |
| Ferry | 6 | 317.9 | 2 | 322.2 | 9 | 482.0 | 1 | 53.3 | 5 | 267.7 | 1 | 53.1 |
| Franklin | 25 | 138.3 | 24 | 131.2 | 45 | 224.0 | 41 | 193.6 | 46 | 208.3 | 98 | 426.6 |
| Garfield | 1 | 166.2 | 0 | 168.3 | 1 | 170.1 | 1 | 171.6 | 0 | 0.0 | 0 | 0.0 |
| Grant | 19 | 79.1 | 25 | 78.7 | 48 | 198.4 | 38 | 155.3 | 39 | 156.9 | 28 | 110.7 |
| Grays Harbor | 103 | 603.7 | 96 | 607.7 | 80 | 472.6 | 80 | 472.8 | 74 | 438.9 | 59 | 352.9 |
| Island | 47 | 257.7 | 47 | 258.0 | 25 | 136.4 | 29 | 157.2 | 22 | 118.5 | 25 | 134.4 |
| Jefferson | 20 | 399.2 | 25 | 400.9 | 25 | 496.8 | 29 | 570.4 | 29 | 569.1 | 28 | 553.2 |
| King | 921 | 237.2 | 827 | 238.5 | 801 | 206.8 | 721 | 184.8 | 622 | 158.3 | 799 | 202.3 |
| Kitsap | 91 | 148.1 | 92 | 148.2 | 111 | 181.6 | 135 | 219.9 | 112 | 182.7 | 173 | 281.9 |
| Kittitas | 24 | 345.6 | 45 | 344.8 | 28 | 397.4 | 19 | 266.5 | 19 | 262.8 | 21 | 285.1 |
| Klickitat | 5 | 99.2 | 10 | 100.4 | 7 | 140.6 | 29 | 579.0 | 26 | 521.3 | 7 | 140.3 |
| Lewis | 102 | 565.3 | 86 | 569.9 | 103 | 573.9 | 81 | 447.3 | 83 | 455.1 | 75 | 412.0 |
| Lincoln | 2 | 81.4 | 3 | 81.7 | 2 | 83.6 | 4 | 167.2 | 3 | 125.5 | 2 | 83.9 |
| Mason | 45 | 395.2 | 66 | 395.6 | 47 | 408.8 | 51 | 437.7 | 59 | 497.6 | 52 | 430.2 |
| Okanogan | 21 | 198.5 | 16 | 201.0 | 29 | 280.4 | 19 | 184.5 | 25 | 245.0 | 21 | 206.4 |
| Pacific | 40 | 930.6 | 15 | 940.3 | 9 | 211.3 | 7 | 164.7 | 14 | 332.1 | 26 | 620.1 |
| Pend Oreille | 12 | 401.7 | 1 | 403.7 | 1 | 33.2 | 5 | 166.3 | 2 | 65.6 | 2 | 65.3 |
| Pierce | 360 | 185.8 | 409 | 185.1 | 394 | 200.9 | 361 | 181.3 | 338 | 167.3 | 446 | 218.2 |
| San Juan | 12 | 444.0 | 8 | 442.4 | 9 | 328.1 | 13 | 473.8 | 4 | 145.8 | 8 | 292.0 |
| Skagit | 82 | 302.1 | 95 | 299.7 | 103 | 372.8 | 120 | 429.4 | 84 | 297.4 | 107 | 375.0 |
| Skamania | 12 | 471.0 | 9 | 467.0 | 16 | 616.4 | 11 | 415.2 | 13 | 490.0 | 12 | 456.0 |
| Snohomish | 335 | 197.0 | 333 | 196.7 | 355 | 206.4 | 281 | 160.6 | 277 | 156.0 | 278 | 155.2 |
| Spokane | 398 | 372.8 | 408 | 374.0 | 320 | 300.3 | 446 | 414.7 | 522 | 481.1 | 425 | 388.1 |
| Stevens | 31 | 275.7 | 41 | 278.5 | 40 | 358.6 | 32 | 283.3 | 43 | 376.0 | 28 | 243.3 |
| Thurston | 187 | 355.1 | 237 | 353.0 | 270 | 501.4 | 300 | 544.6 | 264 | 468.9 | 245 | 425.6 |
| Wahkiakum | 4 | 468.5 | 4 | 475.4 | 2 | 234.6 | 6 | 711.8 | 1 | 117.0 | 6 | 693.7 |
| Walla Walla | 48 | 362.2 | 28 | 360.7 | 29 | 216.8 | 42 | 314.4 | 41 | 307.3 | 35 | 263.2 |
| Whatcom | 155 | 381.3 | 180 | 379.8 | 172 | 417.0 | 189 | 453.3 | 154 | 364.5 | 195 | 458.8 |
| Whitman | 12 | 169.0 | 8 | 168.5 | 4 | 55.7 | 12 | 167.3 | 7 | 98.7 | 13 | 183.5 |
| Yakima | 426 | 610.6 | 351 | 612.8 | 389 | 559.6 | 304 | 435.9 | 320 | 457.5 | 294 | 420.3 |
| **TOTAL** | 4,092 | 269.2 | 4,072 | 267.6 | 4,019 | 262.4 | 3,990 | 257.6 | 3,811 | 243.5 | 4,069 | 257.9 |

* Admissions rate per 100,000 population ages 0-18. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

# Washington State Youth Treatment Admissions for Methamphetamine Per 100,000 in Population




300+
200 to 300
100 to 200
50 to 100
0 to 50

Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

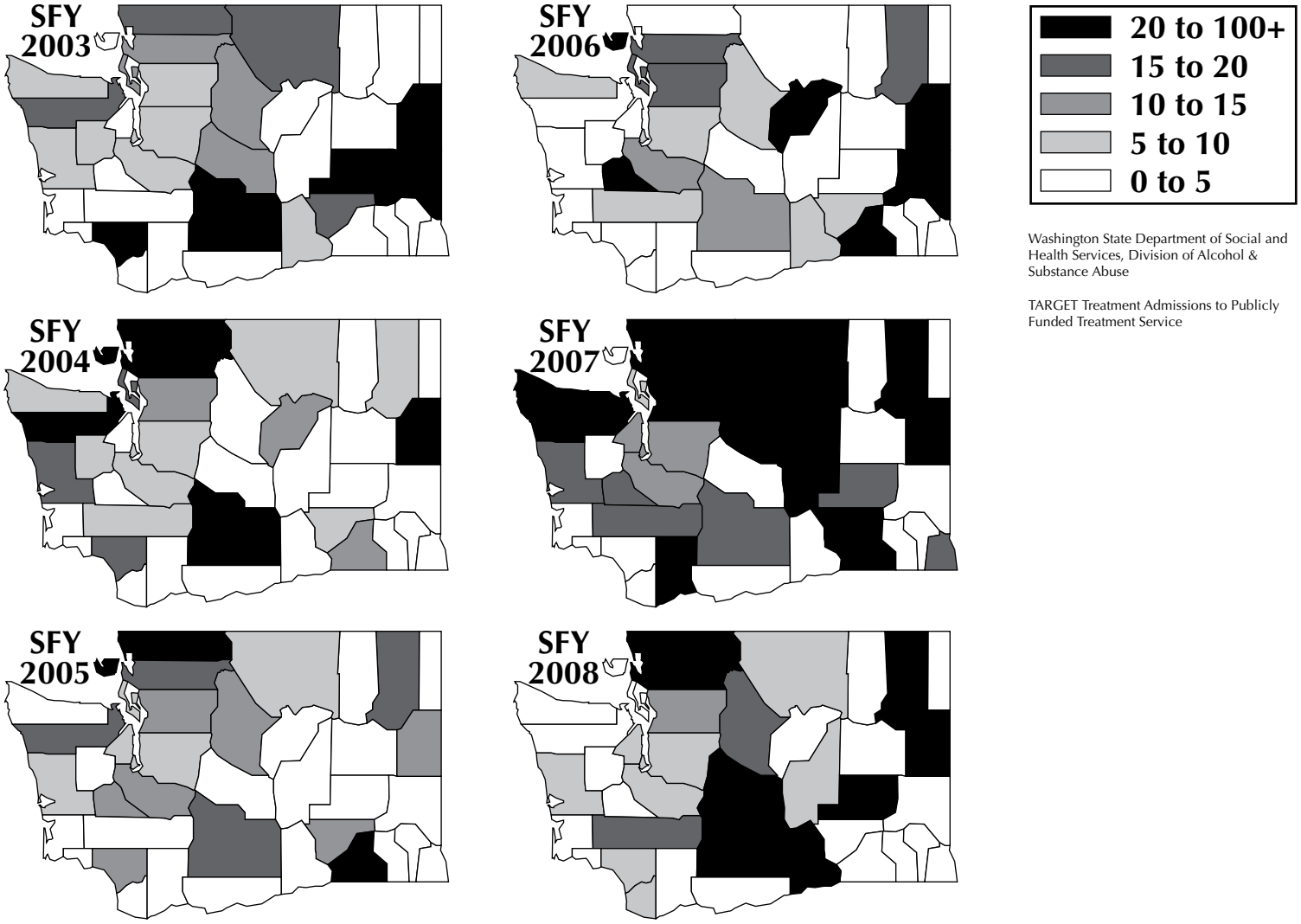
TARGET Treatment Admissions to Publicly Funded Treatment Service

# Washington State Youth Treatment Admissions* Primary Drug = Methamphetamine

| County Name | SFY 2003 | | SFY 2004 | | SFY 2005 | | SFY 2006 | | SFY 2007 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Adams | 0 | 0.0 | 0 | 0.0 | 1 | 18.0 | 0 | 0.0 | 1 | 17.7 | 1 | 17.6 |
| Asotin | 2 | 39.5 | 7 | 139.2 | 1 | 19.9 | 6 | 119.3 | 5 | 99.3 | 0 | 0.0 |
| Benton | 11 | 25.1 | 20 | 45.1 | 25 | 55.8 | 22 | 48.7 | 16 | 35.2 | 14 | 30.5 |
| Chelan | 11 | 59.8 | 9 | 49.1 | 13 | 70.7 | 14 | 75.8 | 7 | 37.6 | 6 | 32.1 |
| Clallam | 20 | 144.5 | 29 | 210.6 | 13 | 94.2 | 19 | 137.1 | 5 | 36.1 | 8 | 57.9 |
| Clark | 37 | 35.7 | 45 | 42.6 | 68 | 63.5 | 46 | 42.0 | 19 | 17.0 | 13 | 11.4 |
| Columbia | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 112.1 |
| Cowlitz | 54 | 219.7 | 47 | 192.6 | 34 | 139.8 | 31 | 127.4 | 19 | 77.9 | 13 | 53.2 |
| Douglas | 4 | 41.7 | 3 | 31.0 | 3 | 30.9 | 4 | 40.3 | 3 | 30.0 | 3 | 29.6 |
| Ferry | 0 | 0.0 | 1 | 53.7 | 0 | 0.0 | 1 | 53.3 | 0 | 0.0 | 0 | 0.0 |
| Franklin | 2 | 11.1 | 1 | 5.2 | 4 | 19.9 | 7 | 33.1 | 5 | 22.6 | 6 | 26.2 |
| Garfield | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Grant | 0 | 0.0 | 11 | 45.6 | 13 | 53.7 | 9 | 36.8 | 13 | 52.3 | 3 | 11.9 |
| Grays Harbor | 29 | 170.0 | 21 | 123.9 | 39 | 230.4 | 40 | 236.4 | 17 | 100.8 | 16 | 95.7 |
| Island | 3 | 16.4 | 10 | 54.9 | 5 | 27.3 | 11 | 59.6 | 0 | 0.0 | 4 | 21.5 |
| Jefferson | 2 | 39.9 | 2 | 40.1 | 5 | 99.4 | 9 | 177.0 | 2 | 39.3 | 4 | 79.0 |
| King | 79 | 20.3 | 72 | 18.6 | 86 | 22.2 | 48 | 12.3 | 52 | 13.2 | 36 | 9.1 |
| Kitsap | 15 | 24.4 | 22 | 35.8 | 21 | 34.4 | 26 | 42.3 | 25 | 40.8 | 15 | 24.4 |
| Kittitas | 7 | 100.8 | 3 | 43.1 | 5 | 71.0 | 0 | 0.0 | 4 | 55.3 | 0 | 0.0 |
| Klickitat | 0 | 0.0 | 4 | 80.3 | 1 | 20.1 | 2 | 39.9 | 2 | 40.1 | 3 | 60.1 |
| Lewis | 18 | 99.8 | 19 | 106.2 | 26 | 144.9 | 56 | 309.2 | 39 | 213.8 | 15 | 82.4 |
| Lincoln | 1 | 40.7 | 0 | 0.0 | 0 | 0.0 | 1 | 41.8 | 3 | 125.5 | 0 | 0.0 |
| Mason | 11 | 96.6 | 12 | 105.5 | 17 | 147.9 | 16 | 137.3 | 14 | 118.1 | 7 | 57.9 |
| Okanogan | 2 | 18.9 | 5 | 47.8 | 2 | 19.3 | 1 | 9.7 | 2 | 19.6 | 0 | 0.0 |
| Pacific | 1 | 23.3 | 1 | 23.5 | 2 | 47.0 | 4 | 94.1 | 1 | 23.7 | 2 | 47.7 |
| Pend Oreille | 0 | 0.0 | 1 | 33.6 | 0 | 0.0 | 3 | 99.8 | 1 | 32.8 | 0 | 0.0 |
| Pierce | 64 | 33.0 | 72 | 37.0 | 68 | 34.7 | 60 | 30.1 | 50 | 24.7 | 29 | 14.2 |
| San Juan | 2 | 74.0 | 1 | 36.9 | 1 | 36.5 | 0 | 0.0 | 2 | 72.9 | 2 | 73.0 |
| Skagit | 13 | 47.9 | 18 | 65.8 | 15 | 54.3 | 16 | 57.3 | 17 | 60.2 | 7 | 24.5 |
| Skamania | 3 | 117.8 | 3 | 116.8 | 7 | 269.7 | 4 | 151.0 | 1 | 37.7 | 1 | 38.0 |
| Snohomish | 61 | 35.9 | 81 | 47.5 | 107 | 62.2 | 81 | 46.3 | 90 | 50.7 | 55 | 30.7 |
| Spokane | 57 | 53.4 | 93 | 87.4 | 81 | 76.0 | 104 | 96.7 | 57 | 52.5 | 46 | 42.0 |
| Stevens | 3 | 26.7 | 2 | 18.0 | 1 | 9.0 | 6 | 53.1 | 6 | 52.5 | 2 | 17.4 |
| Thurston | 41 | 77.9 | 59 | 111.4 | 81 | 150.4 | 95 | 172.4 | 49 | 87.0 | 23 | 40.0 |
| Wahkiakum | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 118.6 | 0 | 0.0 | 0 | 0.0 |
| Walla Walla | 5 | 37.7 | 3 | 22.5 | 4 | 29.9 | 13 | 97.3 | 15 | 112.4 | 6 | 45.1 |
| Whatcom | 22 | 54.1 | 27 | 66.2 | 53 | 128.5 | 76 | 182.3 | 58 | 137.3 | 36 | 84.7 |
| Whitman | 0 | 0.0 | 3 | 42.1 | 3 | 41.8 | 9 | 125.5 | 3 | 42.3 | 3 | 42.3 |
| Yakima | 45 | 64.5 | 50 | 71.9 | 85 | 122.3 | 73 | 104.7 | 73 | 104.4 | 36 | 51.5 |
| **TOTAL** | 625 | 41.1 | 757 | 49.7 | 890 | 58.1 | 914 | 59.0 | 676 | 43.2 | 416 | 26.4 |

* Admissions rate per 100,000 population ages 0-18. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

# Washington State Youth Treatment Admissions for Cocaine Per 100,000 in Population




Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

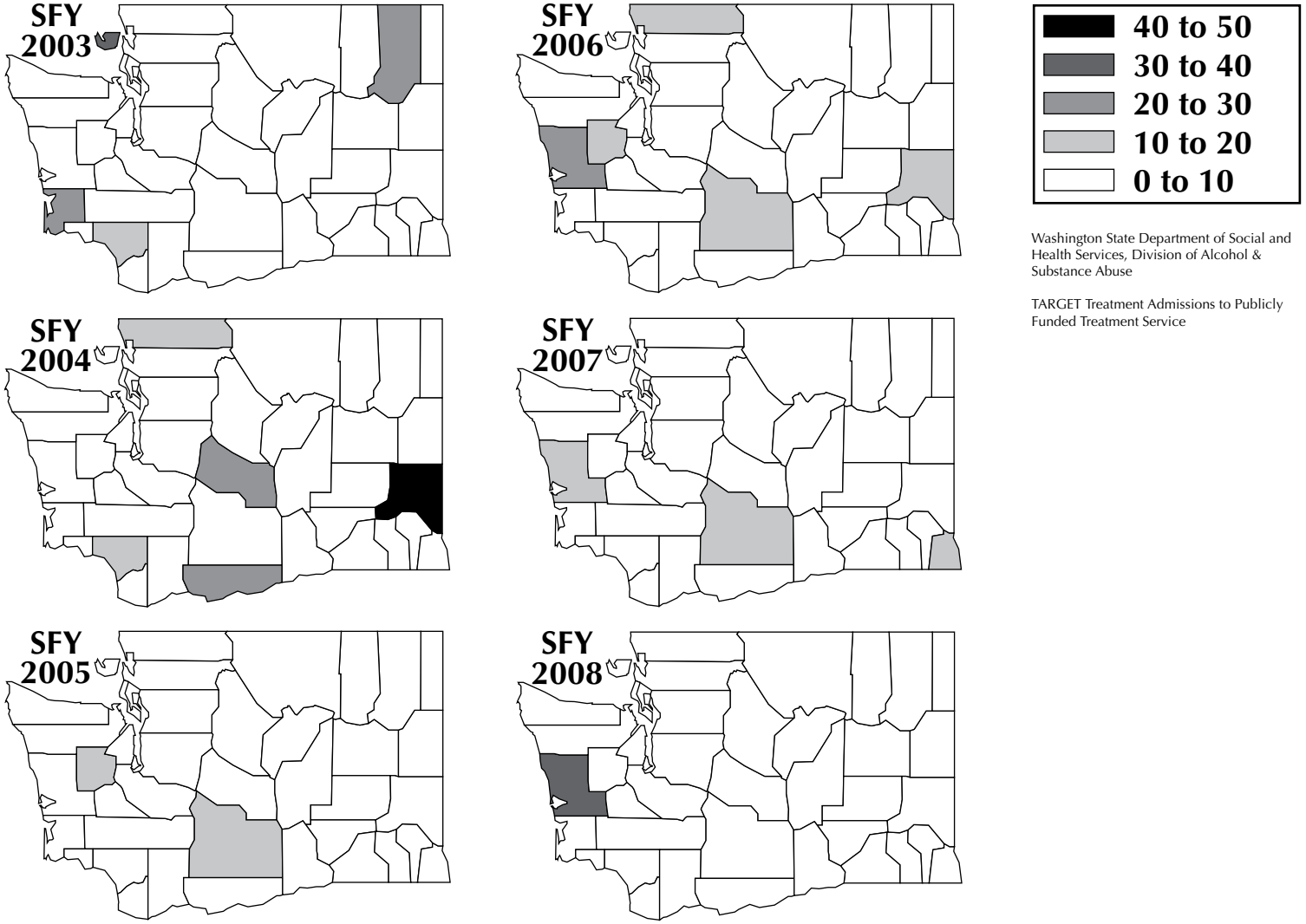
TARGET Treatment Admissions to Publicly Funded Treatment Service

# Washington State Youth Treatment Admissions* Primary Drug = Cocaine

| County Name | SFY 2003 | | SFY 2004 | | SFY 2005 | | SFY 2006 | | SFY 2007 | | SFY 2008 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Adams | 2 | 36.3 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 17.7 | 2 | 35.2 |
| Asotin | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 19.9 | 0 | 0.0 |
| Benton | 3 | 6.9 | 1 | 2.3 | 2 | 4.5 | 4 | 8.9 | 6 | 13.2 | 12 | 26.2 |
| Chelan | 2 | 10.9 | 0 | 0.0 | 2 | 10.9 | 1 | 5.4 | 4 | 21.5 | 3 | 16.0 |
| Clallam | 1 | 7.2 | 1 | 7.3 | 0 | 0.0 | 1 | 7.2 | 3 | 21.7 | 0 | 0.0 |
| Clark | 1 | 1.0 | 1 | 0.9 | 1 | 0.9 | 2 | 1.8 | 2 | 1.8 | 6 | 5.3 |
| Columbia | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Cowlitz | 7 | 28.5 | 4 | 16.4 | 3 | 12.3 | 0 | 0.0 | 0 | 0.0 | 2 | 8.2 |
| Douglas | 0 | 0.0 | 1 | 10.3 | 0 | 0.0 | 3 | 30.2 | 2 | 20.0 | 0 | 0.0 |
| Ferry | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Franklin | 3 | 16.6 | 1 | 5.2 | 3 | 14.9 | 2 | 9.4 | 6 | 27.2 | 1 | 4.4 |
| Garfield | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Grant | 1 | 4.2 | 1 | 4.1 | 1 | 4.1 | 1 | 4.1 | 6 | 24.1 | 2 | 7.9 |
| Grays Harbor | 1 | 5.9 | 3 | 17.7 | 1 | 5.9 | 0 | 0.0 | 3 | 17.8 | 1 | 6.0 |
| Island | 2 | 11.0 | 3 | 16.5 | 1 | 5.5 | 3 | 16.3 | 1 | 5.4 | 0 | 0.0 |
| Jefferson | 1 | 20.0 | 2 | 40.1 | 1 | 19.9 | 0 | 0.0 | 2 | 39.3 | 0 | 0.0 |
| King | 22 | 5.7 | 35 | 9.1 | 30 | 7.7 | 24 | 6.2 | 52 | 13.2 | 36 | 9.1 |
| Kitsap | 0 | 0.0 | 3 | 4.9 | 5 | 8.2 | 3 | 4.9 | 7 | 11.4 | 6 | 9.8 |
| Kittitas | 1 | 14.4 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 3 | 40.7 |
| Klickitat | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Lewis | 0 | 0.0 | 1 | 5.6 | 0 | 0.0 | 1 | 5.5 | 3 | 16.4 | 3 | 16.5 |
| Lincoln | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Mason | 1 | 8.8 | 1 | 8.8 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Okanogan | 2 | 18.9 | 1 | 9.6 | 1 | 9.7 | 0 | 0.0 | 3 | 29.4 | 1 | 9.8 |
| Pacific | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Pend Oreille | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Pierce | 10 | 5.2 | 11 | 5.7 | 26 | 13.3 | 22 | 11.0 | 30 | 14.8 | 14 | 6.8 |
| San Juan | 0 | 0.0 | 1 | 36.9 | 2 | 72.9 | 5 | 182.2 | 0 | 0.0 | 0 | 0.0 |
| Skagit | 4 | 14.7 | 8 | 29.2 | 5 | 18.1 | 5 | 17.9 | 8 | 28.3 | 13 | 45.6 |
| Skamania | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 37.7 | 0 | 0.0 |
| Snohomish | 11 | 6.5 | 24 | 14.1 | 23 | 13.4 | 28 | 16.0 | 36 | 20.3 | 23 | 12.8 |
| Spokane | 28 | 26.2 | 26 | 24.4 | 12 | 11.3 | 23 | 21.4 | 37 | 34.1 | 26 | 25.6 |
| Stevens | 0 | 0.0 | 1 | 9.0 | 2 | 17.9 | 2 | 17.7 | 5 | 43.7 | 3 | 26.1 |
| Thurston | 2 | 3.8 | 0 | 0.0 | 6 | 11.1 | 13 | 23.6 | 11 | 19.5 | 1 | 1.7 |
| Wahkiakum | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Walla Walla | 0 | 0.0 | 2 | 15.0 | 5 | 37.4 | 14 | 104.8 | 8 | 60.0 | 0 | 0.0 |
| Whatcom | 8 | 19.7 | 17 | 41.7 | 20 | 48.5 | 17 | 40.8 | 15 | 35.5 | 10 | 23.5 |
| Whitman | 3 | 42.2 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Yakima | 19 | 27.2 | 18 | 25.9 | 11 | 15.8 | 9 | 12.9 | 12 | 17.2 | 21 | 30.0 |
| **TOTAL** | 135 | 8.9 | 167 | 11.0 | 163 | 10.6 | 262 | 16.7 | 265 | 16.9 | 191 | 12.1 |

* Admissions rate per 100,000 population ages 0-18. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

# Washington State Youth Treatment Admissions for Heroin Per 100,000 in Population




Washington State Department of Social and Health Services, Division of Alcohol & Substance Abuse

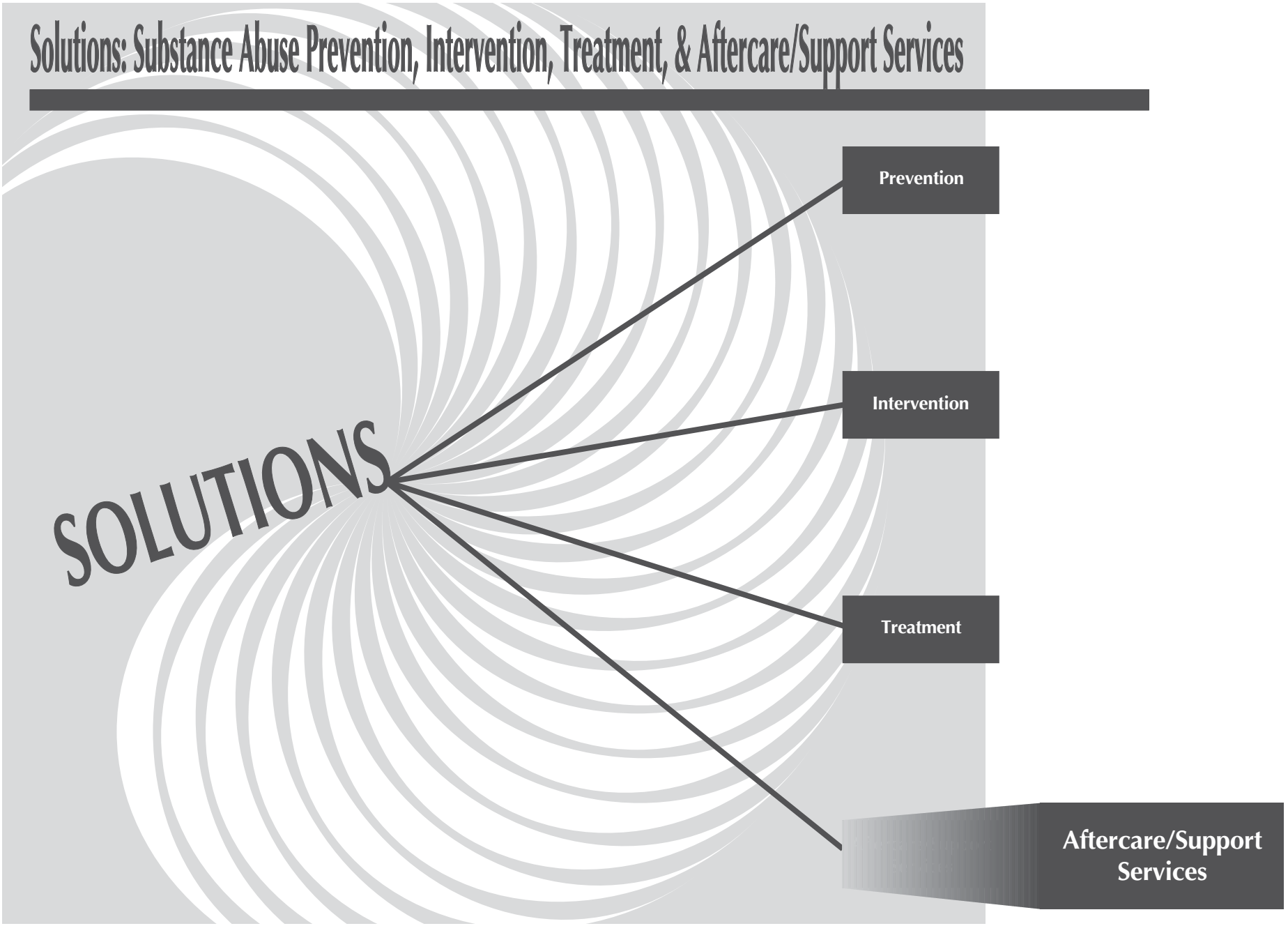
TARGET Treatment Admissions to Publicly Funded Treatment Service

# Washington State Youth Treatment Admissions* Primary Drug = Heroin

| County Name | SFY 2003 | | SFY 2004 | | SFY 2005 | | SFY 2006 | | SFY 2007 | | SFY 2008 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate | Number | Rate |
| Adams | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Asotin | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 19.9 | 0 | 0.0 |
| Benton | 1 | 2.3 | 10 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Chelan | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Clallam | 2 | 1.9 | 50 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Clark | 2 | 1.9 | 5 | 4.7 | 0 | 0.0 | 4 | 3.7 | 5 | 4.5 | 7 | 6.2 |
| Columbia | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Cowlitz | 4 | 16.3 | 3 | 12.3 | 0 | 0.0 | 1 | 4.1 | 1 | 4.1 | 2 | 8.2 |
| Douglas | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Ferry | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Franklin | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Garfield | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Grant | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 1 | 4.0 |
| Grays Harbor | 0 | 0.0 | 0 | 0.0 | 1 | 5.9 | 4 | 23.6 | 3 | 17.8 | 6 | 35.9 |
| Island | 0 | 0.0 | 1 | 5.5 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Jefferson | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| King | 8 | 2.1 | 5 | 1.3 | 6 | 1.5 | 6 | 1.5 | 6 | 1.5 | 13 | 3.3 |
| Kitsap | 0 | 0.0 | 3 | 4.9 | 1 | 1.6 | 2 | 3.3 | 0 | 0.0 | 1 | 1.6 |
| Kittitas | 0 | 0.0 | 1 | 20.1 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Klickitat | 0 | 0.0 | 1 | 20.1 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Lewis | 1 | 5.5 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Lincoln | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 17.2 | 0 | 0.0 | 0 | 0.0 |
| Mason | 0 | 0.0 | 0 | 0.0 | 2 | 17.4 | 2 | 17.2 | 0 | 0.0 | 0 | 0.0 |
| Okanogan | 0 | 0.0 | 0 | 0.0 | 1 | 9.7 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Pacific | 1 | 23.3 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Pend Oreille | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Pierce | 2 | 1.0 | 3 | 1.5 | 0 | 0.0 | 5 | 2.5 | 4 | 2.0 | 0 | 0.0 |
| San Juan | 1 | 37.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Skagit | 1 | 3.7 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Skamania | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Snohomish | 3 | 1.8 | 2 | 1.2 | 5 | 2.9 | 6 | 1.9 | 12 | 6.8 | 9 | 5.0 |
| Spokane | 2 | 1.9 | 4 | 3.8 | 2 | 1.9 | 2 | 1.9 | 0 | 0.0 | 4 | 3.7 |
| Stevens | 3 | 26.7 | 0 | 0.0 | 0 | 0.0 | 0 | 1.8 | 0 | 0.0 | 1 | 8.7 |
| Thurston | 2 | 3.8 | 2 | 3.8 | 1 | 1.9 | 1 | 1.8 | 1 | 1.8 | 5 | 8.7 |
| Wahkiakum | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Walla Walla | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 | 0 | 0.0 |
| Whatcom | 3 | 7.4 | 7 | 17.2 | 1 | 2.4 | 6 | 14.4 | 4 | 9.5 | 2 | 4.7 |
| Whitman | 0 | 0.0 | 4 | 56.2 | 0 | 0.0 | 1 | 13.9 | 0 | 0.0 | 0 | 0.0 |
| Yakima | 1 | 1.4 | 4 | 5.8 | 7 | 10.1 | 8 | 11.5 | 8 | 11.4 | 3 | 4.3 |
| **TOTAL** | 35 | 2.3 | 45 | 3.0 | 27 | 1.8 | 49 | 3.2 | 45 | 2.9 | 54 | 3.4 |

* Admissions rate per 100,000 population ages 0-18. Excludes detox, transitional housing, group care enhancement, private pay, and Department of Corrections. Includes total admissions – counts may be duplicated for an individual based on multiple admissions or multiple modalities of care.

# Solutions: Substance Abuse Prevention, Intervention, Treatment, & Aftercare/Support Services



# Aftercare and Support Services

There is increasing recognition that while treatment is critical for individuals who are chemically dependent to turn their lives around, aftercare and support services are important adjuncts in helping to ensure individuals can move toward healthy lifestyles and return to active, productive lives in their families and communities.

Through a federal grant, DASA's *Access to Recovery (ATR)* program provides recovery services to individuals and families. These include: mental health counseling, medical care, preventive services for family members, childcare, transportation, and housing assistance. What is unique about ATR is that the program is customer-driven, with patients selecting from a menu of services those they believe are most critical in aiding them on the path to recovery.

Washington State is home to more than 200 *Oxford Houses*, with over 1,700 Oxford House beds, the largest number of any state in the country. These are cooperative houses in communities that provide post-treatment housing to individuals who participate in recovery programs. Each house is alcohol- and drug-free. There are several houses exclusively for women, and for parents with children.

Through the *Parent-Child Assistance Program (PCAP),* DASA offers paraprofessional advocacy services for substance-abusing women with young children. Advocates help women identify and prioritize realistic goals and steps to meet them, make referrals to chemical dependency treatment and recovery services where needed, and help individuals access local resources.

DASA's *Safe Babies, Safe Moms* programs provides up to 18 months of housing support services for chemically dependent women who are pregnant, postpartum, or parenting and for their children in drug-free residences.

**Toward a Recovery-Oriented System of Care**

Although addiction is considered a chronic disease, most treatment is oriented towards acute care interventions rather than a disease management approach. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) is leading a national effort to shift to a chronic care approach known as a recovery-oriented system of care. This approach recognizes that recovery from alcohol and other drug problems is a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life, and that there are multiple paths to recovery.[1]

A recovery-oriented system of care builds upon the continuum of care in recognizing the critical role an individual's home and community plays in recovery. It builds upon the continuum of care by providing a role for faith-based and community-based providers, and by expanding client choices in the recovery process. As recovery-oriented systems of care become more generally accepted, there will be need for increased support for the continuing development of recovery support services responsive to the needs of individuals and families.

[1] Center for Substance Abuse Treatment. *The Role of Recovery Support Services in Recovery-Oriented Systems of Care.* Rockville, MD: U.S. Department of Social and Health Services, Substance Abuse and Mental Health Administration, May 2008.

# Access to Recovery (ATR)

Beginning in 2004, Washington State has received grant funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to set up an Access to Recovery (ATR) pilot program. ATR is designed to provide vouchers to pay for services or purchase needed items to eliminate barriers and support individuals in their recovery.

The goal of ATR is to expand capacity and increase the array of faith-based and community-based providers of treatment and recovery support services. Critical to the program is individual choice: once a client is assessed, and a recovery plan established, the client can choose any authorized provider for each recovery service identified. Examples of recovery services include: mental health counseling, transportation, preventive services for family members, housing assistance, child care, job readiness/vocational counseling. All clients receive case management services. Through individual choice, clients are provided the flexibility needed to find their own paths to recovery.

ATR was implemented in Washington's six largest counties: Clark, King, Pierce, Snohomish, Spokane, and Yakima. As of July 2009, more than 16,000 individuals received treatment and recovery support services under the two grants. Average ATR expenditure per client was $1,200.

In December 2007, Washington State received a second three-year ATR grant of $13.9 million from SAMHSA. Under ATR II, individuals with a recent history of methamphetamine use or incarceration receive priority in enrollment. In addition, the Division of Alcohol and Substance Abuse has added a priority for National Guard and military veterans returning from duty in Iraq or Afghanistan who are in need of recovery support services.

# Profile of Individuals Participating in Access to Recovery (ATR) in Washington State

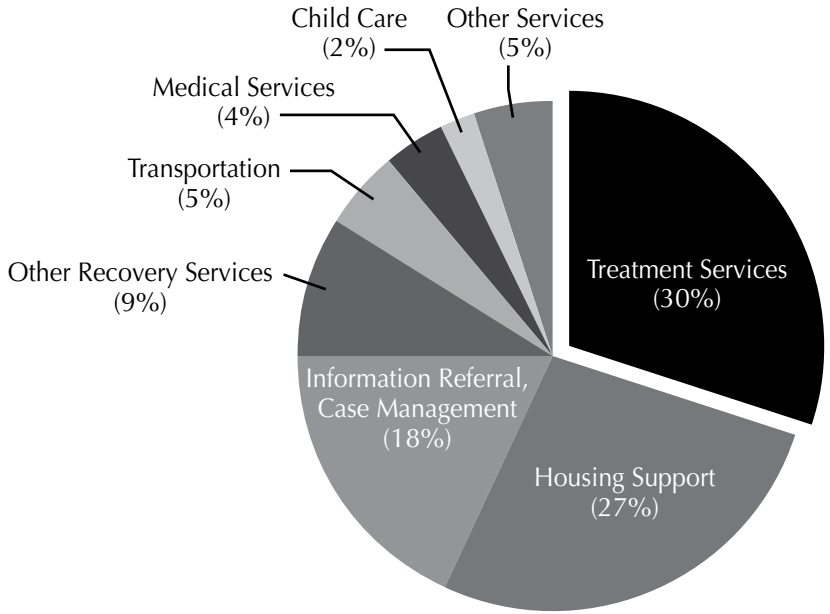
A profile of individuals receiving services funded by the first Access to Recovery (ATR I) grant, September 2004 through October 2007, reveals the following profile:[1]

| | |
|---|---|
| *Number of Individuals Participating:* | 11,343 |
| *Number/% in Treatment during Active ATR Recovery Plan:* | 9,732 (86%) |
| *Median Age*:* | 37 |
| *Race/Ethnicity*:* | Caucasian - 70%; African-American - 12%; Asian/Pacific Islander - 2%; American Indian - 5%; Other/Multi-Race - 11%. Hispanic Origin - 11%. |
| *Employment Status**:* | Employed (full- or part-time) - 18%; Unemployed - 82% |
| *Primary Substance of Abuse**:* | Alcohol - 35%; Methamphetamine - 19%; Heroin - 19%; Cocaine - 11%. |
| *% with Previous Admission**:* | 40% |
| *Criminal Justice Involvement**:* | 54% arrested at least once in previous year |
| *% with Children in the Home**:* | 23% |
| *% with Co-Occurring Disorders:* | 30% with co-occurring mental health disorders |
| *Housing Status**:* | 16% homeless*** |

* Includes unduplicated individuals having an ATR voucher with an active ATR recovery plan.
** Includes individuals with an active ATR recovery admission admitted to publicly funded chemical dependency treatment.
***Includes homeless, shelter/mission, on the street, transient quarters, no stable arrangement categories.

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, September 2009. Data includes unduplicated admissions to the Access to Recovery Program, September 2004 - October 2007.

# Some 70% of Access to Recovery I Funds were Used for Recovery Support Services.

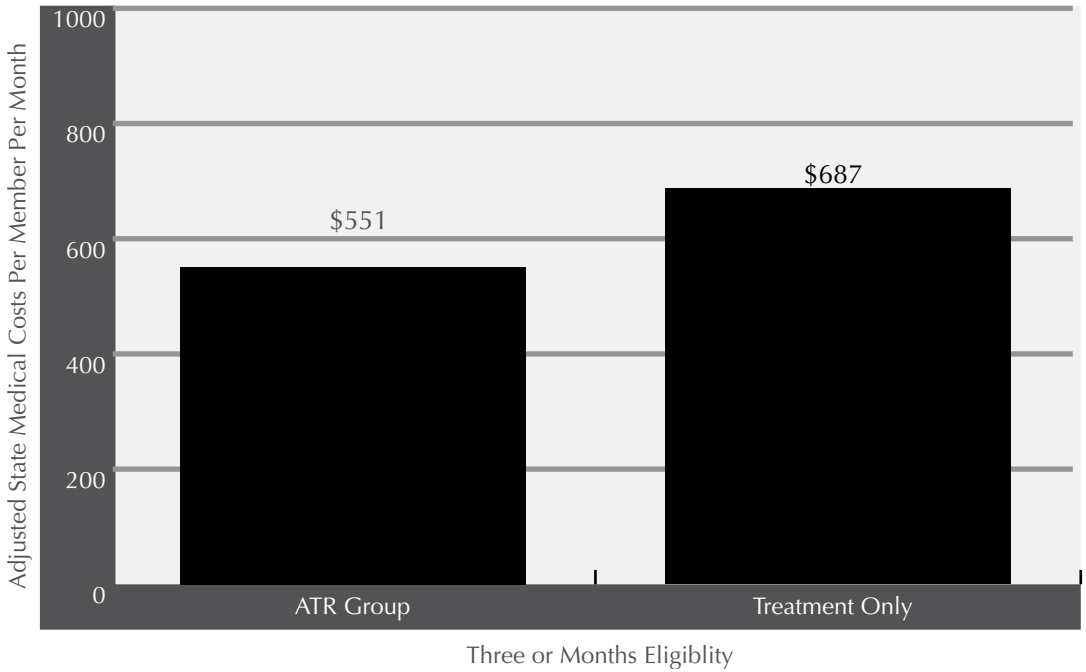



Source: Wickizer, T., and Lucenko, B., *Access to Recovery Services Help Contain Medical Costs for Chemically Dependent Clients – Report 4.72*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, November 2008.

Access to Recovery (ATR) I expanded capacity and access to an array of faith-based and community-based treatment and recovery support services. As part of their recovery plans, ATR clients can choose among authorized providers to receive services, which may include: mental health counseling, transportation, preventive services for family members, housing assistance, child care, job readiness/vocational counseling. All clients receive case management services.

While under ATR I (2004-2007), 30% of funds were expended for treatment services, virtually no funds are being expended for this purpose under the current ATR II grant.

# Medical Costs for Working-Aged Disabled Clients were Lower for Patients Who Received Recovery Support Services in Addition to Chemical Dependency Treatment.

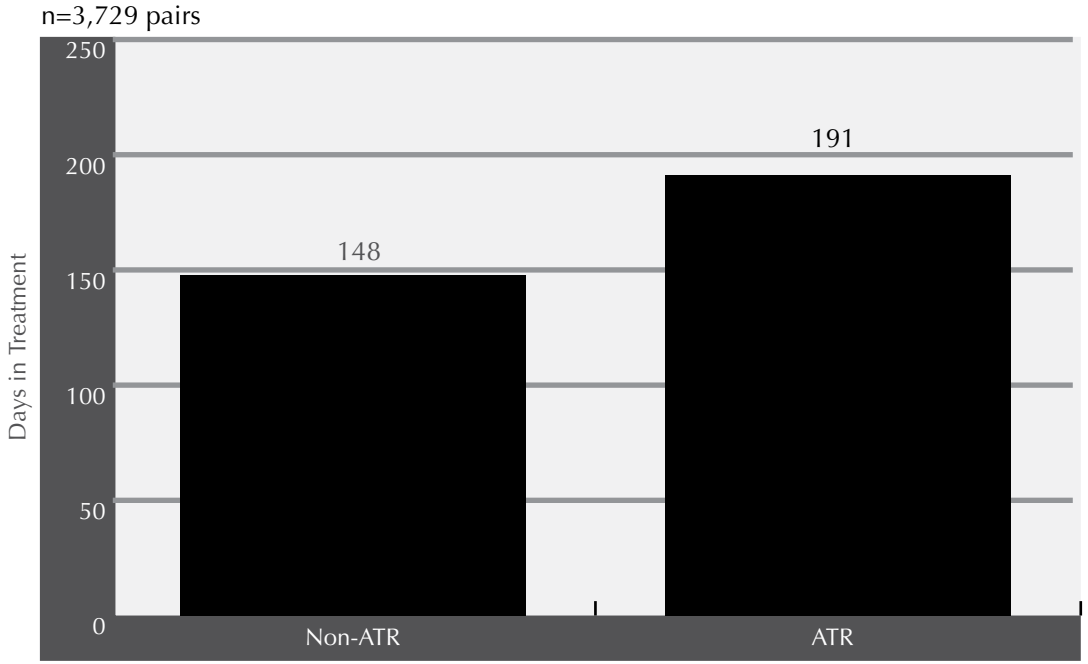



Source: Wickizer, T., and Lucenko, B., *Access to Recovery Services Help Contain Medical Costs for Chemically Dependent Clients – Report 4.72*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, November 2008.

This graph indicates that working-aged disabled clients who received recovery support services through Access to Recovery (ATR) in addition to chemical dependency treatment had lower state-paid medical costs than those who received treatment alone. As part of their recovery plans, ATR clients can choose among authorized providers to receive recovery support services, which may include: mental health counseling, transportation, preventive services for family members, housing assistance, child care, job readiness/vocational counseling. All clients receive case management services.

While under ATR I (2004-2007), 30% of funds were expended for treatment services, virtually all funds are being expended for recovery support services under the current ATR II grant.

# Patients Who Received Services Through Access to Recovery (ATR) Stayed in Chemical Dependency Treatment 29% Longer than Those Who Did Not Receive ATR Services.



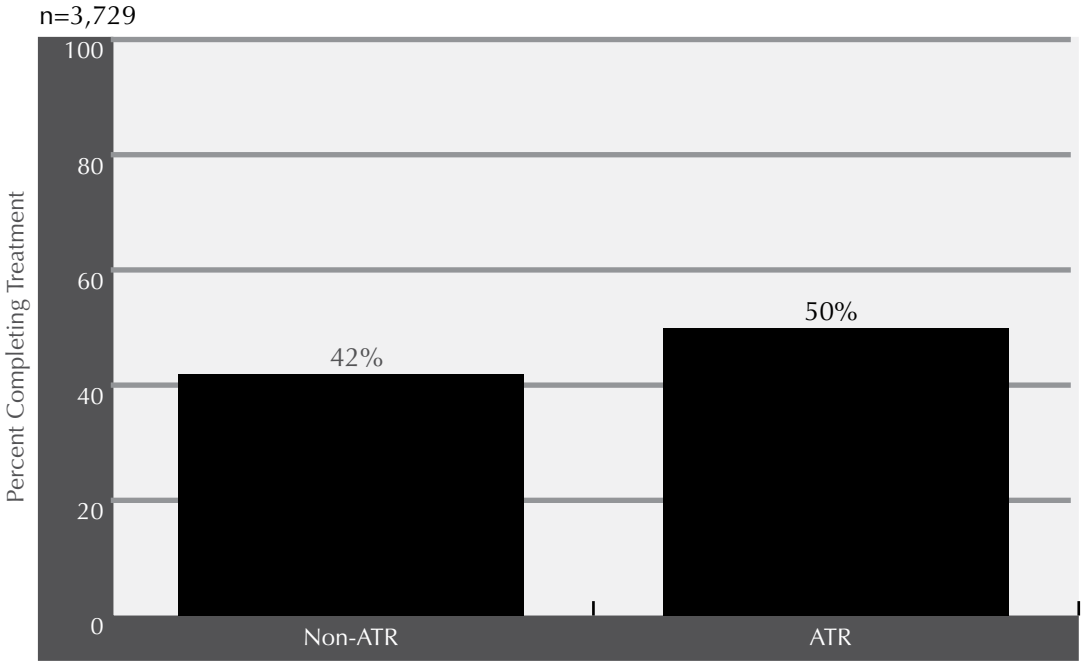

Source: Krupski, T., et al., *Improved Outcomes for Clients Who Receive Access to Recovery (ATR) Services in Publicly Funded Chemical Dependency Treatment*. Seattle, WA: Harborview Medical Center, Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations, December 2008.

A recent study compared patient outcomes of individuals receiving Access to Recovery (ATR) services while in chemical dependency treatment with clients who did not receive ATR services. On average, patients who received ATR services remained in treatment longer.[1] Length-of-stay in treatment is associated with longer-term positive outcomes.



[1] Krupski, T., et al. *Improved Outcomes for Clients Who Receive Access to Recovery (ATR) Services in Publicly Funded Chemical Dependency Treatment*. Seattle, WA: Harborview Medical Center, Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations, December 2008.

# Patients Who Received Services Through Access to Recovery (ATR) were 19% More Likely to Complete Chemical Dependency Treatment than Those Who Did Not Receive ATR Services.

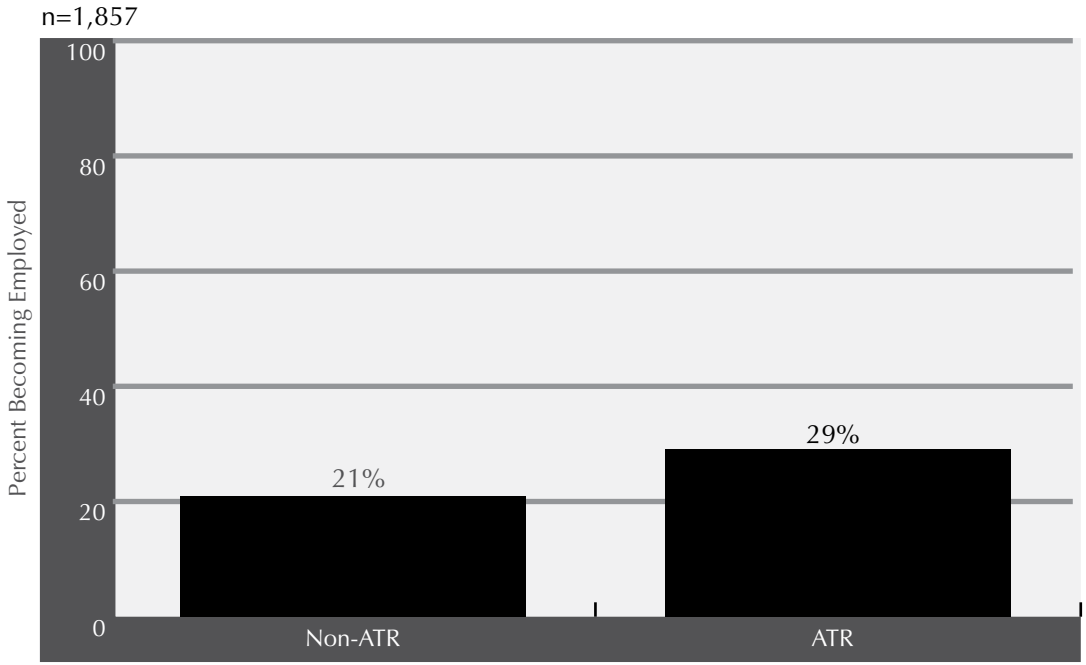



Source: Krupski, T., et al., *Improved Outcomes for Clients Who Receive Access to Recovery (ATR) Services in Publicly Funded Chemical Dependency Treatment*. Seattle, WA: Harborview Medical Center, Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations, December 2008.

More than 11,800 individuals received Access to Recovery (ATR) services between September 2004 and October 2007. A recent study compared patient outcomes of individuals receiving services while in chemical dependency treatment with clients who did not receive ATR services. On average, patients who received ATR services were significantly more likely to complete treatment.[1] Treatment completion is associated with better long-term outcomes.

[1] Krupski, T., et al. *Improved Outcomes for Clients Who Receive Access to Recovery (ATR) Services in Publicly Funded Chemical Dependency Treatment.* Seattle, WA: Harborview Medical Center, Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations, December 2008.

# Clients with No Earning History in the Prior Year Who Received Access to Recovery (ATR) Services were 38% More Likely to Become Employed in the Following Nine Months than Non-ATR Clients.




Source: Krupski, T., et al., *Improved Outcomes for Clients Who Receive Access to Recovery (ATR) Services in Publicly Funded Chemical Dependency Treatment*. Seattle, WA: Harborview Medical Center, Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations, December 2008.

In 2004, Washington State received a three-year, $22.8 million grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to set up an Access to Recovery (ATR) pilot program. More than 11,300 individuals received Access to Recovery (ATR) services between September 2004 and October 2007. A recent study compared client outcomes of individuals receiving services through ATR with clients who did not receive ATR services. On average, clients who with no earnings history in the prior year who received ATR services were significantly more likely to become employed in the following nine months. In addition, these clients earned 31% more than non-ATR clients.[1]



[1] Krupski, T., et al. *Improved Outcomes for Clients Who Receive Access to Recovery (ATR) Services in Publicly Funded Chemical Dependency Treatment*. Seattle, WA: Harborview Medical Center, Center for Healthcare Improvement for Addictions, Mental Illness and Medically Vulnerable Populations, December 2008.

# Washington State Leads the Nation in the Number of Oxford Houses Established.

Oxford Houses are independent, peer-run, alcohol- and drug-free housing for individuals in recovery. Each house is financially self-supporting, and offers a highly supportive peer environment for individuals impacted by alcohol and other drug abuse and addiction.

House member elect officers for six-month terms. Residents share in the total expenses of the houses, with costs for individual members ranging from $275-$450 per month. Applicants must be voted in by 80% of current members. They are often referred to Oxford Houses by counselors at the completion of treatment programs, as well as by 12-step support groups, drug courts, jails and prisons, and other agencies. Applicants are usually expected to have a personal recovery plan. There is a zero tolerance policy toward relapse, and individuals are asked to leave immediately if they use alcohol or other drugs. People are permitted to remain in the houses as long as they choose, with average length of stay being 13-15 months for men, and 8-9 months for women.

The first Oxford House in the United States was established in 1975; the first in Washington State in 1989. Currently, Washington State has approximately one-sixth of all the Oxford Houses in the United States. There are currently 205 Oxford Houses in Washington State, in 49 cities and towns, with more than 1,700 beds. These include:

- 141 houses for men.
- Two houses for men with children.
- 41 houses for women.
- 18 houses for women with children.
- Two houses for the deaf and hard-of-hearing.

An average of 20 new houses are being formed each year. Over 2,600 individuals were served in 2008. According to a 2007 resident survey, 68.3% of Oxford House residents had been homeless prior to residence; 78.9% had been in jail. The average length of sobriety was 15.2 months; 44.1% attended weekly counseling sessions in addition to 12-step meetings.[1] Washington State Oxford Houses have an 82% success rate, defined as individuals remaining in recovery for one year or longer.

The Division of Alcohol and Substance Abuse manages a revolving loan fund to finance the start up of Oxford Houses, with loans of up to $4,000 per house. In addition, DASA contracts for four Oxford House outreach workers.

[1] Washington State Division of Alcohol and Substance Abuse. *Highlights of the Washington Stated Oxford House Program*. Olympia, WA: Washington State Department of Social and Health Services, 2009.

# Aftercare/Support Services are Provided to Mothers and Their Children through the Parent Child Assistance Program (PCAP) and Safe Babies Safe Moms Program.

**Parent Child Assistance Program (PCAP)**

PCAP provides advocacy annually to approximately 675 high-risk substance-abusing pregnant and parenting women and their young children in nine Washington counties and the Spokane Reservation. Services are available to women who have given birth to a child diagnosed with Fetal Alcohol Spectrum Disorder (FASD); women who themselves may have an FASD diagnosis; high-risk women who receive inadequate prenatal care and/or who have not successfully accessed community resources for substance-abuse related families.

In addition to referral, support, and advocacy for treatment, PCAP provides assistance in accessing and using local resources such as family planning, safe housing, health care, domestic violence services, parenting skills training, child welfare, childcare, transportation and legal services. Linkages are made to health care and appropriate therapeutic interventions for children, as well as financial assistance for food, unmet health needs, and other necessities. PCAP works closely with community service providers, including mental health provider networks and frequently arranges for multi-disciplinary staff and counseling for clients.

**Safe Babies Safe Moms**

Safe Babies Safe Moms, also known as the Comprehensive Program Evaluation Project (CPEP), annually serves some 250 substance-abusing pregnant, postpartum, and parenting women (PPW) and their children from birth-to-three at project sites in Snohomish, Whatcom, and Benton-Franklin Counties. CPES in a state-level consortium consisting of the Division of Behavioral Health and Recovery, and including the Department of Social and Health Services' Children's Administration, Economic Services Administration, Division of Healthcare Services, Research and Data Analysis Division, and the Department of Health. The purpose of the consortium is to respond the disturbing number of birth of alcohol- and drug-affected infants.

Safe Babies Safe Moms provides a comprehensive range of services. A specialized Targeted Intensive Case Management (TICM) multidisciplinary team serves each site, providing referral, support, and advocacy for chemical dependency treatment and continuing care. TICM assists in accessing local resources, including family planning, safe housing, health care, domestic violence services, parenting skills training, child welfare, childcare, transportation, and legal service. Mental health screening, assessment, and treatment are provided or referrals made as appropriate. Long-term residential chemical dependency treatment programs provide a positive recovery environment with structured clinical services, and during which therapeutic childcare is provided for their children. In addition, following treatment, housing support services for women and children are provided, who stay up to 18 months in transition housing. Recovery support and linkages to community-based services are also provided.

# Treatment Through the Criminal Justice Treatment Account

# Criminal Justice Treatment Account (CJTA)

In 2003, the Legislature and Governor created the Criminal Justice Treatment Account (CJTA). Its history goes back to the previous year, when, in the 2002 Session, the Legislature effected a shift in adult felony drug offender sentencing policy, reducing sentences for many adult felony drug offenses, and designating the projected savings for use in providing substance abuse treatment for offenders, both in prison and in the community.

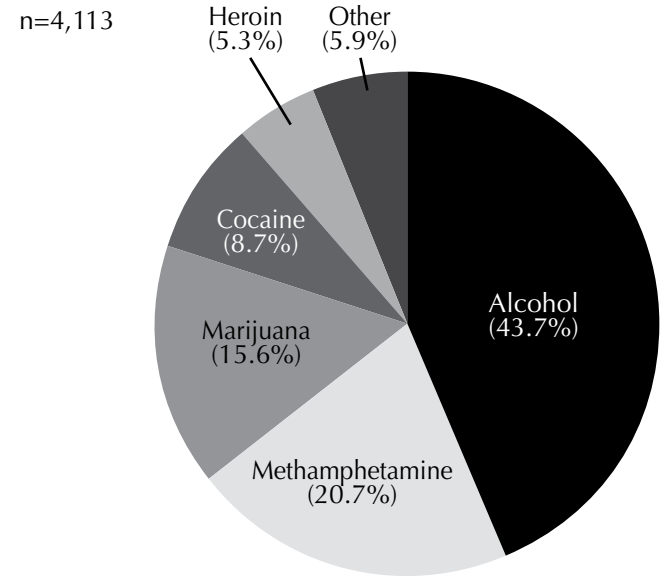
Administered by the Division of Behavioral Health and Recovery (DBHR), CJTA funds are used solely for providing substance abuse treatment and treatment support services for offenders who have a substance abuse problem and have been filed upon by a county prosecutor. The intent is to provide judicially supervised treatment in lieu of incarceration, with the objective of generating additional jail and prison bed savings, both in the short-term through treating offenders rather than incarcerating them, and in the long-term by reducing recidivism among those offenders. Use of the funds is determined at the county level, and may include drug courts, provided the funds are used only for treatment and treatment support services.

In SFY 2008, 4,133 individuals received treatment under CJTA: Of these:

- 71.1% were male; 28.9% were female.
- A plurality (38.4%) were between ages 21-30. Another 24.2% were between ages 31-40.
- 67.2% were Caucasian; 16.9% were Hispanic; 8.1% were African-American.
- 43.7% had alcohol as their primary substance of abuse; 20.7% methamphetamine; 15.6% marijuana.
- 68.3% completed outpatient treatment (compared with 44.8% of non-CJTA patients).

In the SFY 2010 budget, $8,873,000 is allocated to CJTA.

# In State Fiscal Year 2008, Alcohol was the Primary Substance of Abuse for the Majority of Individuals in Treatment Under the Criminal Justice Treatment Account.

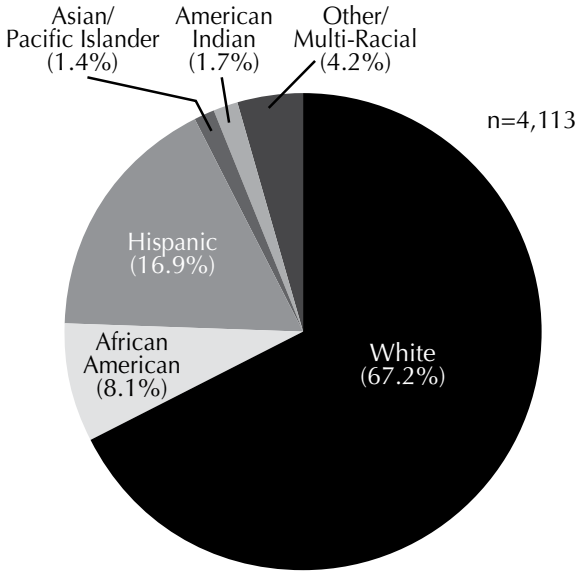



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2009.

In SFY 2008, alcohol was the primary substance of abuse for individuals in treatment under the Criminal Justice Treatment Account (CJTA). Both in Washington State and nationally, alcohol remains the single largest cause of mortality-, crime-, and health-related costs among all substances of abuse.

In SFY 2010, $8,873,000 is being transferred into the CJTA for judicially supervised treatment and treatment support services in lieu of incarceration. The percentage of CJTA clients being treated for methamphetamine abuse and addiction fell from 22.4% in SFY 2007 to 20.7% in SFY 2008.

# In State Fiscal Year 2008, Almost One-Third of Those Receiving Treatment Under the Criminal Justice Treatment Account were Racial and Ethnic Minorities.

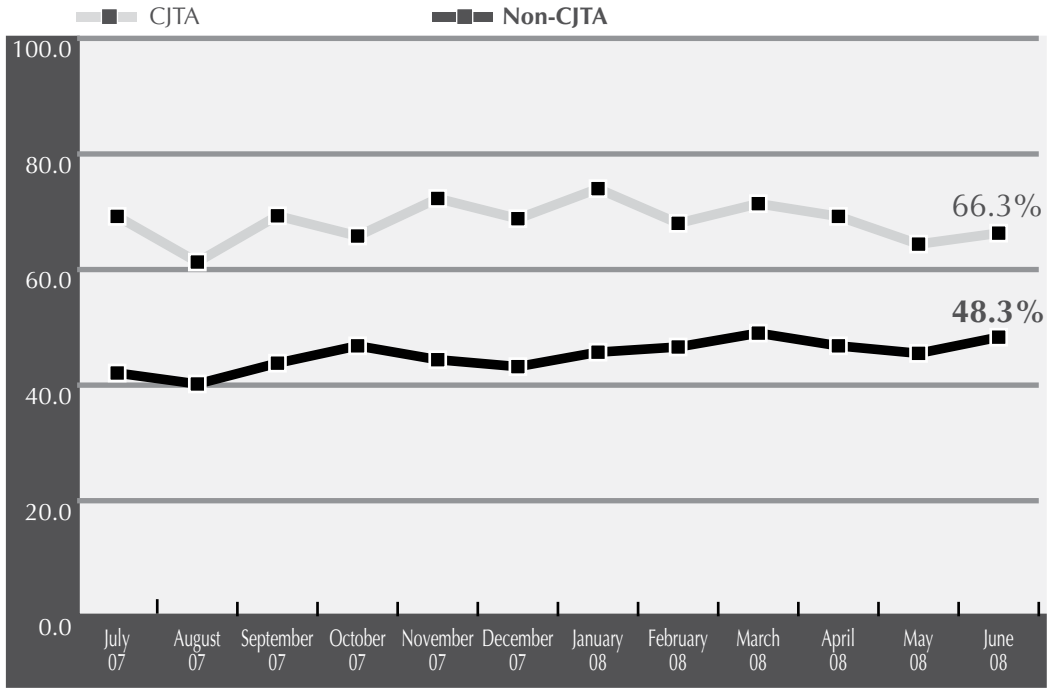



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2009.

In SFY 2008, almost a third of those receiving treatment under the Criminal Justice Treatment Account (CJTA) were racial and ethnic minorities. The median age was 32; 38.4% of patients were between 21 and 30 years old. Some 71% were male, 29% female.

In SFY 2010, $8,873,000 is being transferred into the CJTA for judicially supervised treatment and treatment support services in lieu of incarceration.

# Patients Receiving Outpatient Treatment Under the Criminal Justice Treatment Account were 52% More Likely to Complete Treatment than Other DASA-Funded Patients.




Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services, 2009.

In SFY 2008, patients receiving judicially supervised outpatient care under the Criminal Justice Treatment Account were significantly more likely to complete treatment than other DASA-funded patients (68.3% v. 44.8%). It is likely that the possibility of judicial sanctions has played a role in increasing treatment completion rates.

# Treatment Through the Department of Corrections

# The Washington State Department of Corrections Responds to the Need for Chemical Dependency Treatment.

Over the past decade, the need for quality chemical dependency treatment among inmates in the custody of the Washington State Department of Corrections (DOC) has become increasingly apparent. More than a quarter of individuals (26%) sentenced to DOC custody in SFY 2008 were convicted of drug offenses.[1] An even higher proportion was under the influence of alcohol or other drugs at the time they committed their offense.

Responding to this need, DOC provides a multi-phased continuum of care which includes: addiction pre-screening; comprehensive diagnostic assessment; intensive treatment and aftercare; and coordinated transition and case management services. The treatment regime is abstinence-based, and employs offender-specific, research-based best practices. All 50 DOC treatment sites are certified by the Division of Alcohol and Substance Abuse. The goal of DOC's program is to reduce reoffense, enhance the safety of communities, and prepare offenders for more productive lives once they are released.

Offenders screened and found to be chemically dependent, who are within two years of release from total confinement, or under community supervision, may be referred for a comprehensive diagnostic assessment conducted by a chemical dependency treatment professional, and admitted to treatment according to priorities set by DOC policy:

**Primary Treatment** - DOC provides two primary treatment modalities, which are Residential Therapeutic Community and Intensive Outpatient. The offender's severity of addiction, custody level, risk management classification, and time to serve in total confinement all factor into treatment placement.

- *Residential Therapeutic Community (Long-Term Residential)* is a progressive, phase-based level of care nine to twelve months in length, and is the most intensive form of primary treatment available within DOC. Employing best practices, the modified Residential Therapeutic Community provides separate living area and a highly structured treatment regime combining accountability, an emphasis on "right living", and chemical dependency treatment.

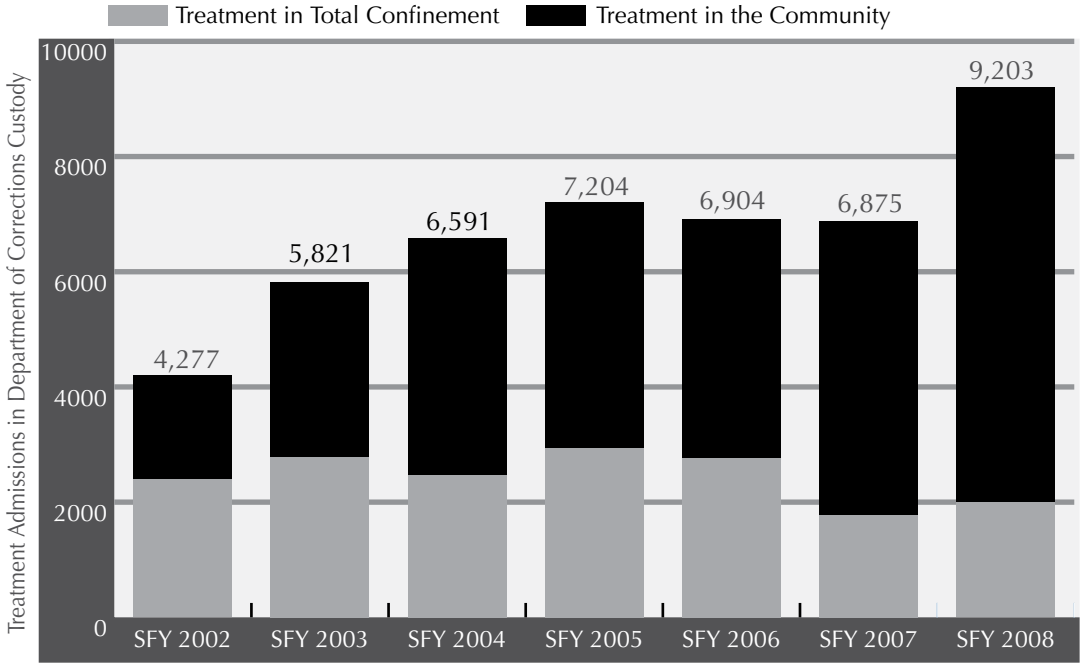
- *Intensive Outpatient (IOP)* is a highly structured intervention available in total and partial confinement facilities, as well as in the community. IOP is offered in varying lengths of stay in order to meet the sentence structure and treatment needs of offenders in different institutions and in the community.

Outpatient Treatment (continuing care or aftercare) - Following completion of any primary level of treatment, offenders are admitted to outpatient treatment. Based on the offender's clinical progress, outpatient treatment may continue as needed, with a minimum of three months of outpatient treatment occurring upon release from total confinement. A transitional therapeutic community outpatient program is available at selected work release sites for those leaving the highly structured therapeutic community environment.

Community-Based Treatment - Offenders sentenced under the Drug Offender Sentencing Alternative (DOSA) and high-risk offenders residing in areas where DOC does not provide treatment are referred to other contract chemical dependency treatment providers for appropriate services. Within available resources, the Department of Corrections reimburses vendors for pre-authorized treatment.

[1] Washington State Department of Corrections, August 2009.

# Washington State Has Made a Major Commitment to Providing Chemical Dependency Treatment to Offenders in Total Confinement and Community Custody.



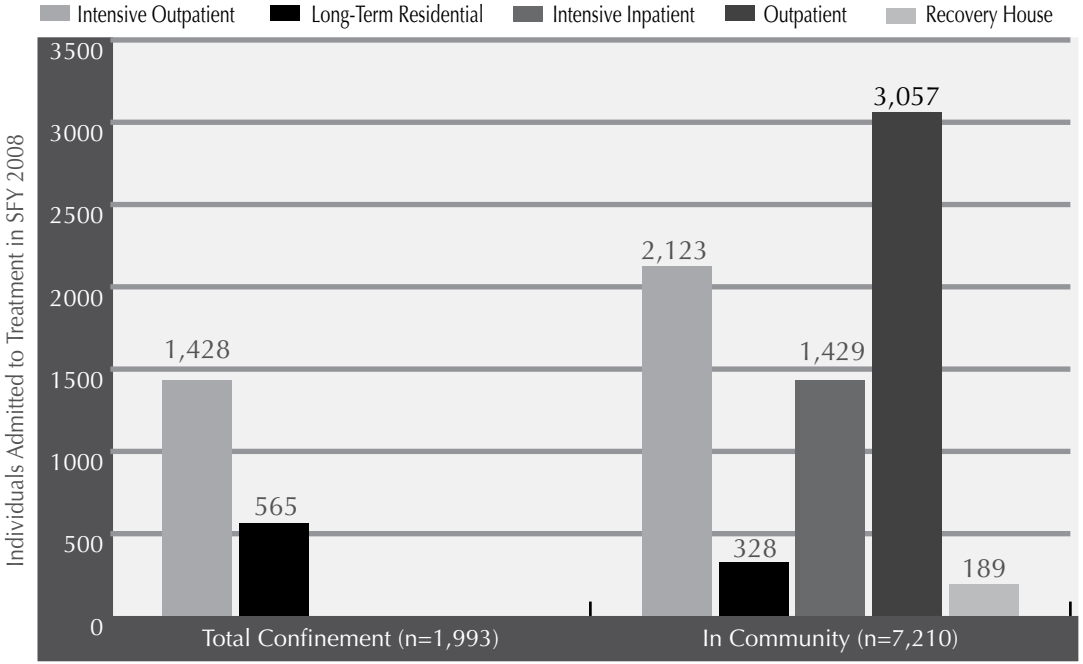

Source: Washington State Department of Corrections, August 2009.

This graph indicates the depth of commitment Washington State has made in recent years toward the provision of alcohol and drug treatment services to offenders in the state correctional system. Especially noteworthy is the expansion of services to offenders in community custody. Admissions to treatment in the community now represent 78% of total admissions.

Consistent with best practices, offenders are admitted to treatment as close to release from total confinement as possible. Based on an offender's clinical progress while in confinement, outpatient treatment may continue as needed, with a minimum of three months of treatment occurring after release.

# The Majority of Individuals Admitted to Chemical Dependency Treatment in the State Correctional System in SFY 2008 Received Intensive Outpatient Treatment.

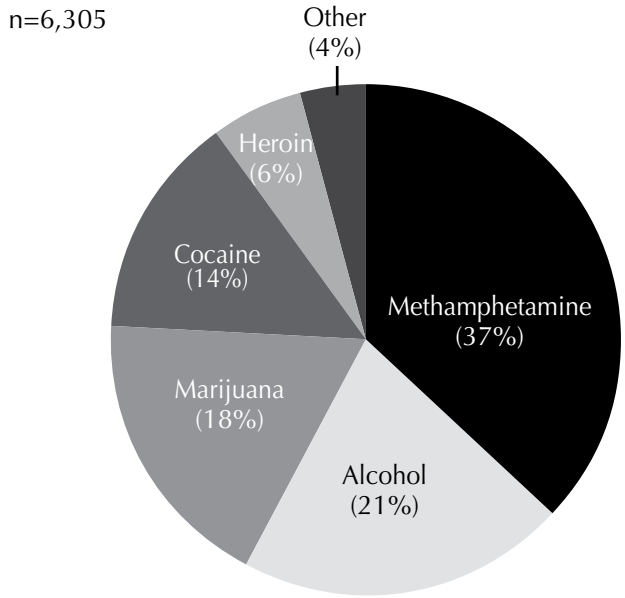
***Offenders in Department of Corrections Custody Admitted to Treatment in SFY 2008***




Source: Washington State Department of Corrections, August 2009.

The Washington State Department of Corrections provides five levels of chemical dependency treatment to offenders in custody who are assessed as in need. Long-term residential treatment is delivered in modified therapeutic communities, providing a highly structured living and treatment environment. Intensive outpatient treatment is provided both in correctional facilities and in communities in the form of highly structured interventions. A minimum of three months of outpatient treatment is provided in the community once an individual leaves total confinement.

# In SFY 2008, More than a Third of Individuals Assessed and Found in Need of Treatment By the Department of Corrections Reported Methamphetamine as Their Primary Substance of Abuse.

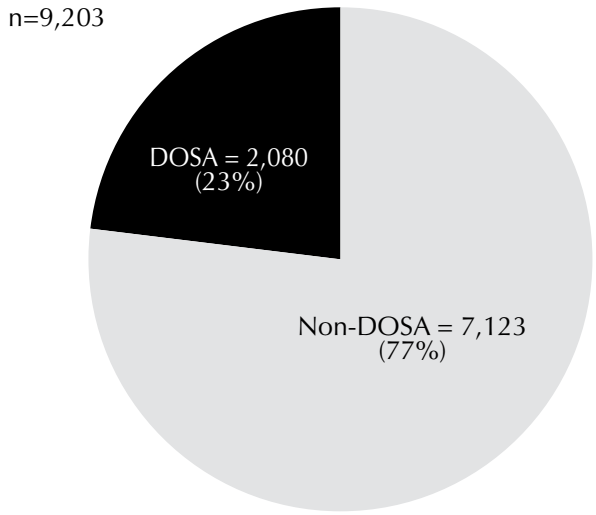



Source: Washington State Department of Corrections, August 2009.

Some 6,305 Department of Corrections clients assessed in SFY 2008 were found to be in need of treatment. The number of clients in need of treatment whose primary substance of abuse was methamphetamine has more than tripled, from 691 in SFY 2001 to 2,290 in SFY 2007.

# In SFY 2008, Nearly a Quarter of Individuals Receiving Chemical Dependency Treatment in the State Correctional System were Sentenced Under the Drug Offender Sentencing Alternative (DOSA).

***Offenders in Department of Corrections Custody Admitted to Treatment in SFY 2008***

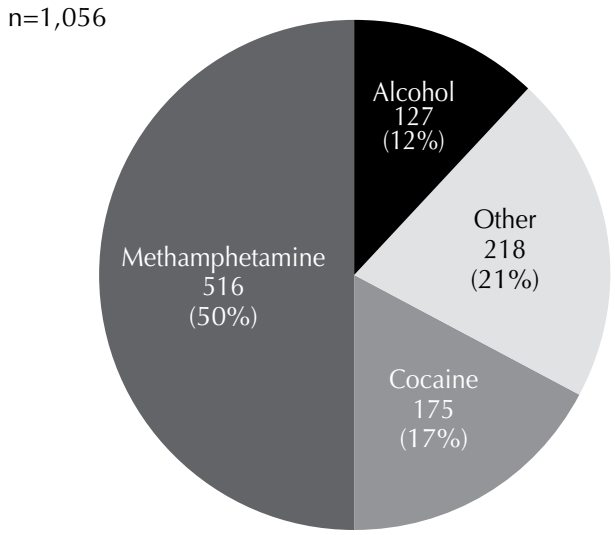



Source: Washington State Department of Corrections, July 2009.

The Drug Offender Sentencing Alternative (DOSA) provides judges with the option of ensuring those offenders who: A) pose a moderate to high risk of reoffense; B) pose a risk to public safety; and C) have had their lives disrupted due to substance abuse problems may receive chemical dependency treatment through the Department of Corrections. To qualify, offenders must have no current or prior sex or violent offenses and must not have used a deadly weapon in the commission of the offense. Additionally, if the offense was a violation of the Uniform Controlled Substance Act, the offense must have involved only a small quantity of illicit drugs.

Under DOSA, the offender serves one half of the mid-point of the standard sentencing range for the offense in total confinement, with the remainder of the term to be served in community custody. During incarceration, offenders undergo a comprehensive substance abuse assessment and receive appropriate treatment services. Services continue when the offender is released into community custody. Failure to meet conditions of the sentence – which can include drug testing and monitoring, and education or employment training – can result in imposition of the balance of the original sentence.

# Half of Individuals Sentenced Under the Drug Offender Sentencing Alternative (DOSA) and Assessed in SFY 2008 Reported Methamphetamine as Their Primary Substance of Abuse.

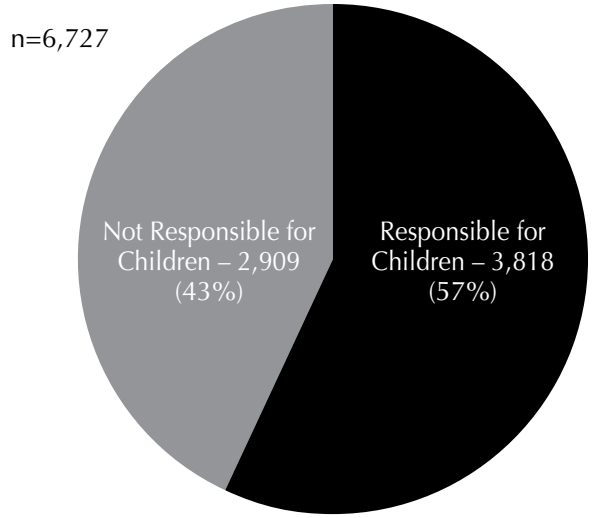



Source: Washington State Department of Corrections, August 2009.

The Drug Offender Sentencing Alternative (DOSA) provides judges with the option of ensuring offenders may receive chemical dependency treatment through the Department of Corrections. Offenders must: A) pose a moderate to high risk of reoffense; B) pose a risk to public safety; and C) have had their lives disrupted by substance abuse problems. Offenders must have no current or prior sex or violence offenses or have used a deadly weapon in commission of the offense. If the offense was a violation of the Uniform Controlled Substance Act, it must have involved only a small quantity of illicit drugs.

Under DOSA, the offender serves one-half of the mid-point of the standard sentencing range for the offense in total confinement, with the remainder in community custody. During incarceration, offenders undergo a comprehensive substance abuse assessment and receive appropriate treatment services. Sentences continue when the offender is released into community custody.

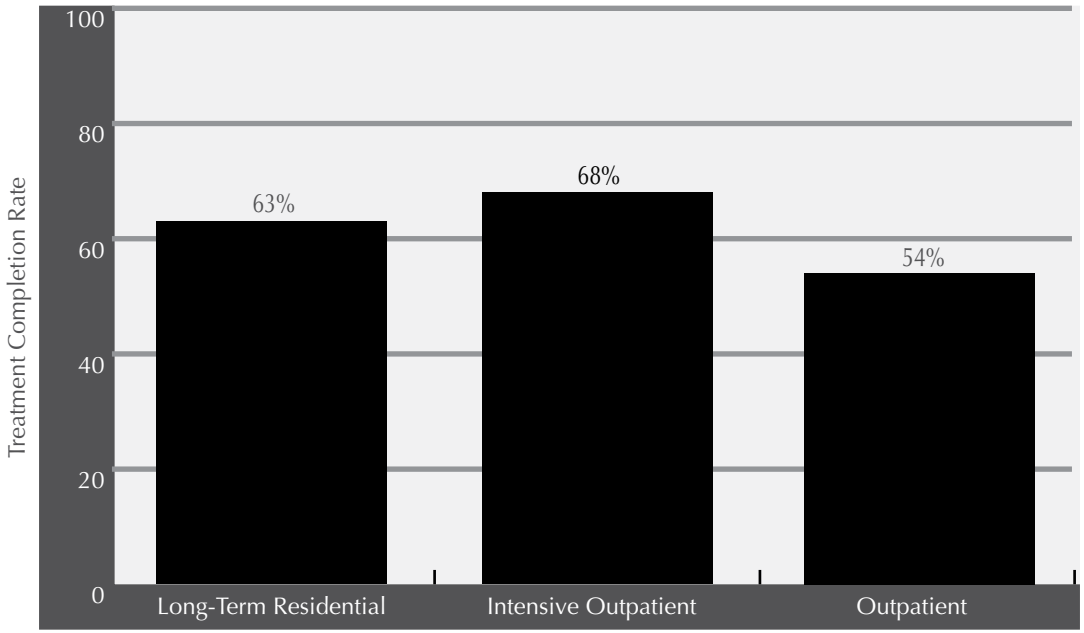
# Almost 60% of Inmates in Department of Corrections Custody Admitted to Chemical Dependency Treatment During SFY 2008 were Responsible for Minor Children.




Source: Washington State Department of Corrections, August 2009.

Well over half of Department of Corrections custody in both total confinement and community custody admitted to chemical dependency treatment in SFY 2008 were responsible for minor children. Chemical dependency treatment is an important step in helping inmates recover from addiction and lead productive lives whereby they can care for their families.

# In SFY 2008, More than Half of Those Receiving Chemical Dependency Treatment Through the Department of Corrections Completed It.

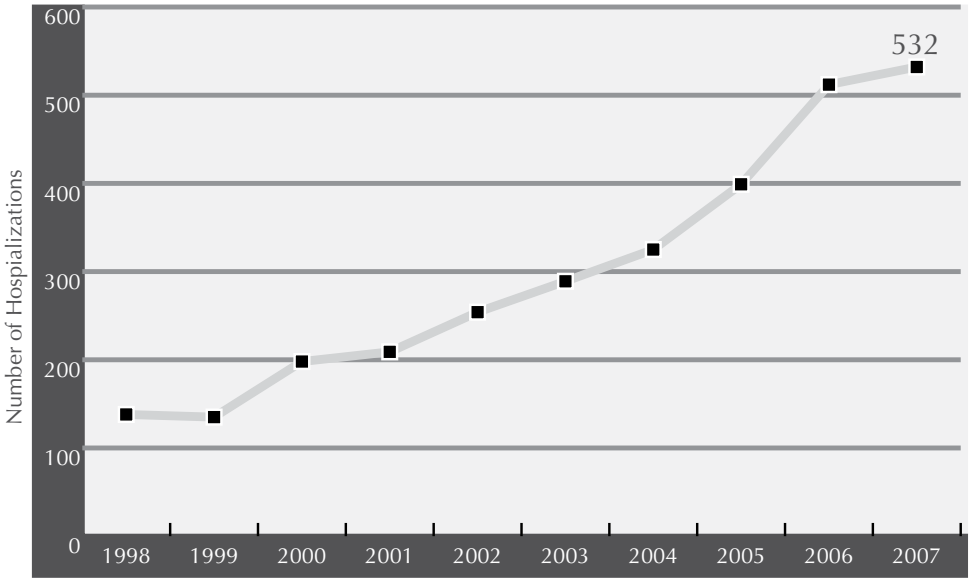



Source: Washington State Department of Corrections, August 2009.

Well more than half of those receiving chemical dependency treatment through the Department of Corrections complete it. Treatment completion is considered an important measure for inmates re-entering the community from incarceration, and should be associated with reduced criminal recidivism.

# Prescription-Type Opiate Abuse and Treatment

# The Number of Overdose Hospitalizations in Washington State for Prescription-Type Opiates* is Four Times Higher than a Decade Ago.




Source: Center for Health Statistics, Washington State Department of Health, 2008.

The expanded use of prescription-type opiates to treat non-cancer pain over the past decade has created new opportunities for diversion and illicit use, with increased risk of overdose hospitalization and death. In 2007, there were 454 drug-caused deaths in Washington State in which prescription-type opiates were involved. Clients, often addicted, may "shop" for more than one prescriber, including hospital emergency departments, creating dangers to themselves, and increasing the pool of prescription-type opiates to be sold illicitly. There was a 47% increase in prescription-type opiate-related emergency department visits in Seattle between 2004 and 2007.[1]

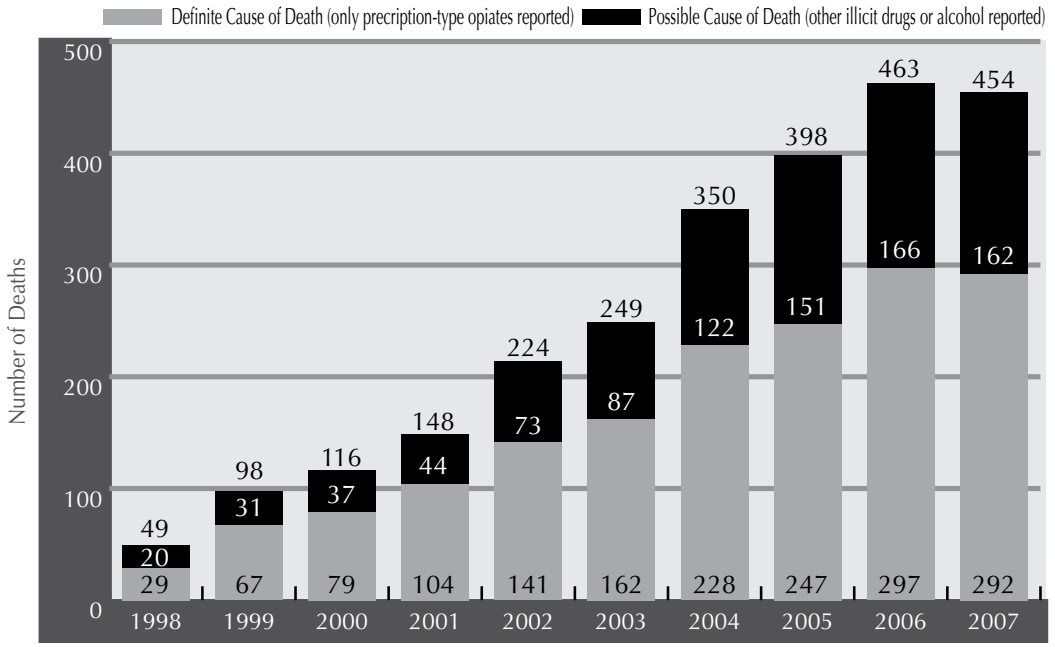
In 2008, 21.7% of Washington State 12 graders reported having used prescription pain killers to get high, 12.0% in the past 30 days. Of these, 51% (or 6.1% of all 12th graders) reported using them three or more times in the past 30 days.[2] Both the health risks and addiction potential of such use are extremely high.

**Defined as opiates other than heroin or morphine. These include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, and propoxyphene.*

[1]Office of Applied Studies. Drug Abuse Warning Network (DAWN): Estimates of Drug-Related Emergency Department Visits: Seattle Nonmedical Use of Pharmaceuticals. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.
[2]Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board. *Healthy Youth Survey – 2008*. Olympia, WA: 2009.

NEW/CHANGING TREND

# The Number of Drug-Caused Deaths in Washington State in Which Prescription-Type Opiates* are Involved is Nine Times Higher than a Decade Ago.




Source: Center for Health Statistics, Washington State Department of Health, 2008.

Over the past decade, the expanded use of prescription-type opiates to treat pain has created new opportunities for diversion and illicit use, often resulting in addiction or death. In SFY 2008, there were 792 Medicaid clients prescribed an average of more than 1,000 morphine equianalgesic dosages (MEDs) per day, far higher than what is normally considered the standard dosage to treat non-cancer pain. Clients may "shop" for more than one prescriber, including hospital emergency departments, creating dangers to themselves, and increasing the pool of prescription-type opiates to be sold illicitly.

Of the 454 drug-caused deaths related to prescription-type opiates in 2007, benzodiazepines were also reported in 93 of them (20.5%). Among high-risk users of prescription-type opiates seen in hospital emergency departments under the Washington State Screening, Brief Intervention, and Referral to Treatment (WASBIRT) Program, days of use per month declined 41% for those who received only a brief intervention, and 54% for those who received a brief intervention plus brief therapy and/or chemical dependency treatment.

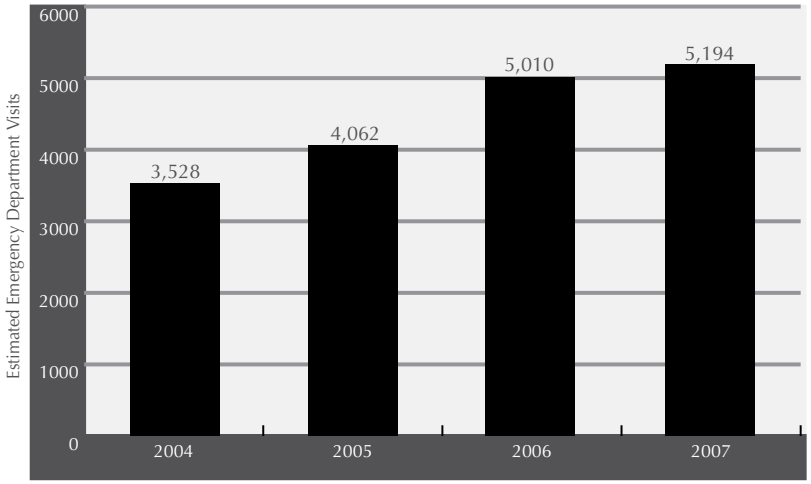
**Defined as opiates other heroin or morphine. These include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, and propoxyphene.*



[1]Best, S. *Utilization Review of High Dose Opioids and Their Prescribers.* Presentation to the Washington State Drug Utilization Review Board, April 2009. Olympia, WA: Washington State Medicaid, Patient Review and Coordination, 2009.

[2] Estee, S., et al. *Use of Alcohol and Other Drugs Declined Among Emergency Department Patients Who Received Brief Interventions for Substance Use Disorders Through WASBIRT – Preliminary Report.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2007.

# Seattle Emergency Department Visits Related to the Non-Medical Use of Prescription-Type Opiates Increased by 47% Between 2004-2007.




Source: Office of Applied Studies, Drug Abuse Warning Network (DAWN). *Estimates of Drug-Related Emergency Department Visits: Seattle Nonmedical Use of Pharmaceuticals. Rockville*, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2008.

The rise of emergency department visits related to the non-medical use of prescription-type opiates parallels the increase in hospitalizations, deaths, and chemical dependency treatment admissions. The expanded use of prescription-type opiates to treat non-cancer pain over the past decade has created new opportunities for diversion and illicit use. Clients, often addicted, may "shop" for more than one prescriber, including hospital emergency departments, creating dangers to themselves, and increasing the pool of prescription-type opiates to be sold illicitly.

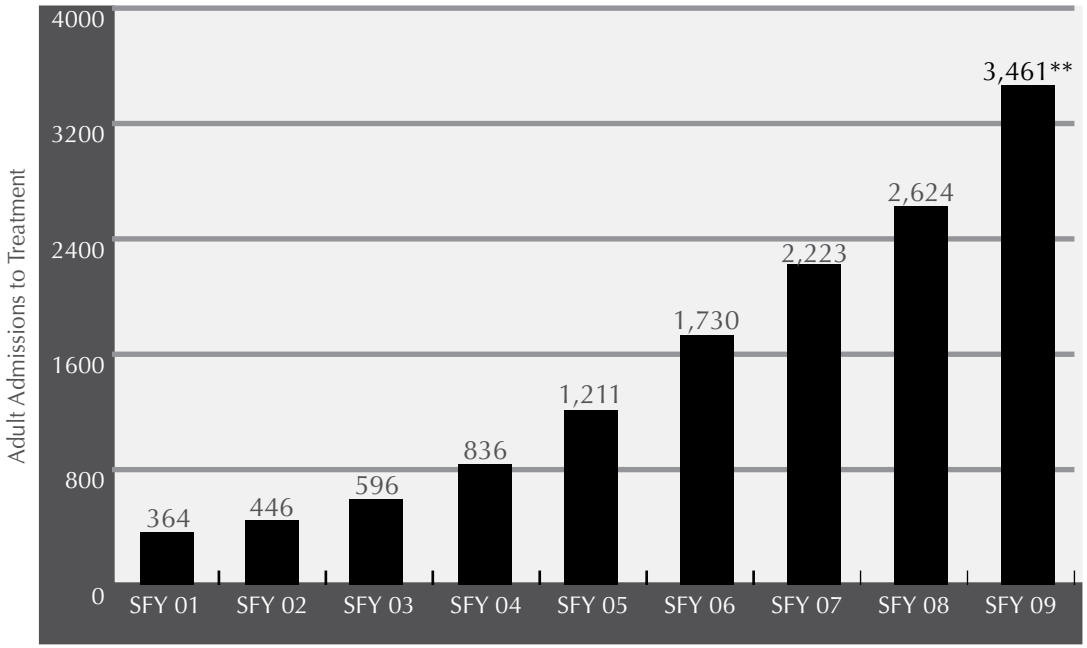
The Department of Social and Health Services Prescription Review and Coordination (PRC) program is a health and safety initiative aimed at state-funded clients who overuse or inappropriately utilize medical services. Among its efforts are those intended to lower medically unnecessary and potentially addictive drug use. PRC identifies high utilizers of prescription-type opiates, those with multiple prescribers, and those who often frequent emergency rooms with non-emergent diagnoses. Once identified, clients are restricted for 24 months to a single primary care provider, pharmacy, controlled substance prescriber, and hospital for non-emergent care. Since SFY 2006, PRC reports for these clients a 33% decrease in emergency room visits, a 37% decrease in physician visits, and a 24% decrease in number of prescriptions. Approximately 3,100 clients are currently served by PRC.[1]

**Defined as opiates other heroin or morphine. These include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, and propoxyphene.*

[1]Coolen, P., and Calderon, L. *Prevention of Abuse and Deaths Due to Prescription Opioids & Patient Review and Coordination Program.* Olympia, WA: Washington State Department of Social and Health Services, Patient Review and Coordination Program, June 2009.

NEW/CHANGING TREND

# Adult Admissions to DASA-Funded Treatment for Prescription-Type Opiates* are Almost Ten Times What They were in SFY 2001.




Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

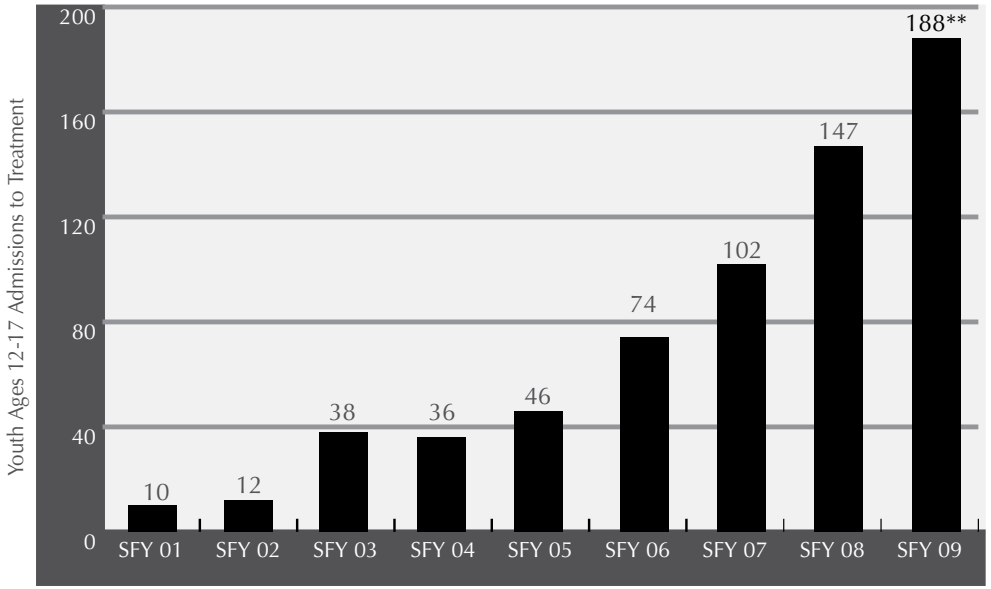
In SFY 2009, 9.5% of adults admitted to treatment whose primary substance of abuse was prescription-type opiates had used drugs intravenously in the past 30 days.[1] Use of prescription opiates is often a precursor to heroin use. A 2009 survey undertaken by the Seattle-King County Needle Exchange found that 39% of heroin users were opiate-dependent prior to heroin use.[2] In addition to those admitted to treatment, in SFY 2009 DASA received 500 requests from Medicaid clients for the use of buprenorphine (Suboxone) as an opiate substitute for either heroin or prescription-type opiates.

**Defined as opiates other than heroin or morphine. These include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, and propoxyphene.*

**Counts for SFY 2009 are likely incomplete.

[1] Treatment and Assessment Report General Toll (TARGET). Olympia, WA: Washington State Department of Social and Health, Division of Alcohol and Substance Abuse, Services, July 2009.
[2] Seattle Needle Exchange. *2009 NX Survey Results.* Seattle, WA: Public Health – Seattle & King County, HIV/AIDS Program, 2009.

# Youth Admissions to DASA-Funded Treatment for Prescription-Type Opiates* are Increasing Rapidly.




Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

Abuse of prescription-type opiates among youth has been increasing rapidly. A 2008 survey of Washington 12th graders found that 21.7% had used prescription painkillers to get high, and 12.0% had done so in the past 30 days. Of those 12th graders who reported using prescription pain killers to get high at least once, 33% said they got them from friends, while 29% used their own prescriptions from a doctor or dentist.

Prescription-type opiates can result in acute health effects, as well as have significant addiction potential. More than half of those 12th graders who reported used prescription painkillers to get high in the past 30 days used them three or more times.[1] Nationally, in 2006, there were more new users of prescription pain relievers by youth (2.15 million) than there were of marijuana.[2]

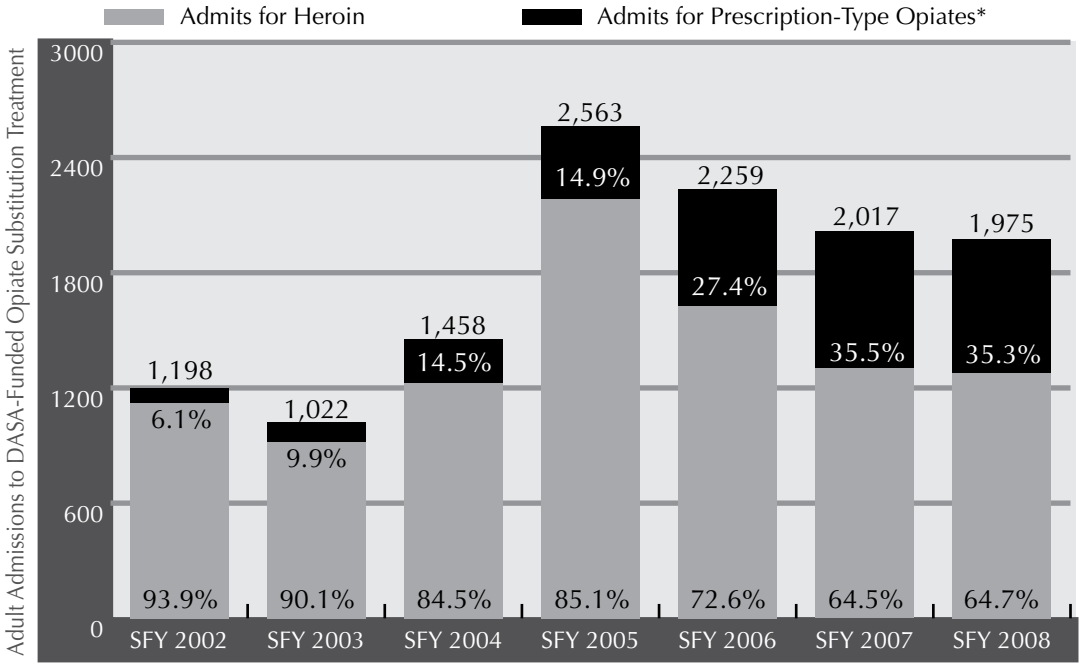
**Defined as opiates other than heroin or morphine. These include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oyxcodone, and propoxyphene.*

**Counts for SFY 2009 are likely incomplete.

[1] Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board. *Healthy Youth Survey – 2008*. Olympia, WA: 2009.
[2] Office of National Drug Control Policy. *Prescription for Danger: A Report on the Troubling Trend of Prescription and Over-the-Counter Drug Abuse Among the Nation's Teens*. Washington, DC: Executive Office of the President, January 2008.

NEW/CHANGING TREND

# The Percentage of All Admissions to DASA-Funded Opiate Substitution Treatment Among Those Addicted to Prescription-Type Opiates Has Risen Rapidly.

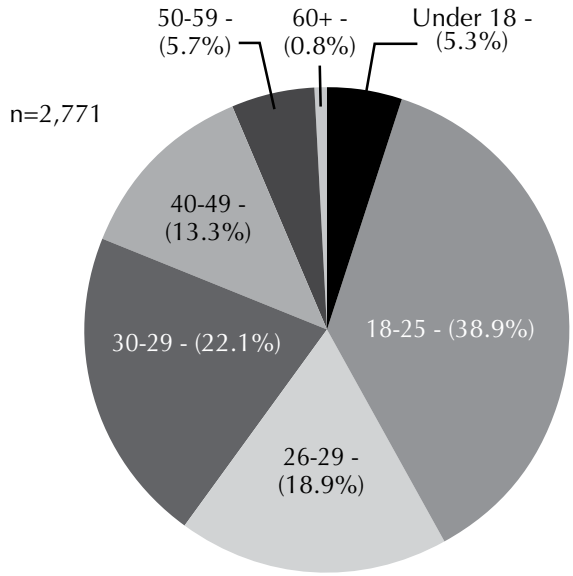



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Alcohol and Substance Abuse, Washington State Department of Social and Health Services.

In recent years, there has been a substantial shift in admissions to DASA-funded opiate substitution treatment. The percentage of those being admitted whose primary substances of abuse are prescription-type opiates has been rising rapidly, with a more than ten-fold increase in such patients since SFY 2002. Almost 15% of these individuals are recent injection drug users.

**Less than 2% are for drugs other than opiates. Prescription-type opiates include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oyxcodone, and propoxyphene.*

# In SFY 2008, Almost Four Out of Ten Admissions to DASA-Funded Treatment for Prescription-Type Opiate* Addiction were for Young Adults Ages 18-25.




Admissions to DASA-Funded Treatment Where Primary Substance of Abuse is Prescription-Type Opiates, By Age – SFY 2008

Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, 2009.

Young adults are disproportionately impacted by prescription-type opiate* addiction, and are entering treatment in substantially higher numbers. The number of DASA-funded admissions among 18-25 year-olds where the primary drug of abuse was prescription-type opiates increased from 104 in SFY 2003 to 938 in SFY 2008. Of these, 40.2% began using prescription-type opiates between the ages of 10-17. In SFY 2008, young adults ages 18-25 made up 26.0% of all individuals addicted to prescription-type opiates entering DASA-funded opiate substitution treatment.[1]

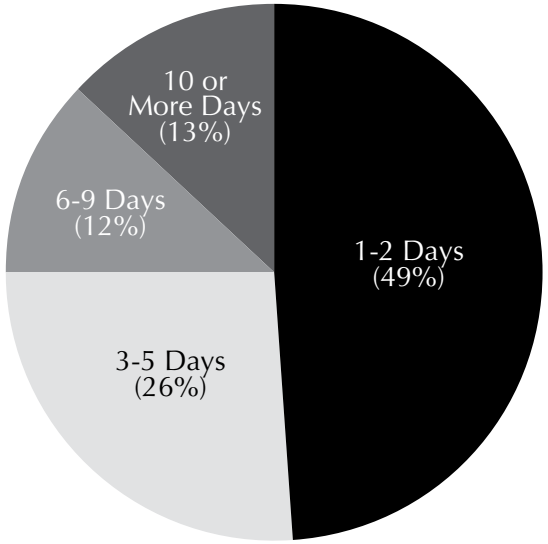
**Prescription-type opiates include: codeine, dihydrocodeine, fentanyl, hydrocodone, methadone, oxycodone, and propoxyphene.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, 2009.

## NEW/CHANGING TREND

# In 2008, More than 6% of Washington State 12th Graders Reported Using Prescription Pain Killers to Get High Three or More Times in the Past 30 Days.

**12th Graders Using Prescription Pain Killers to Get High in the Past 30 Days**




Source: Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board, *Healthy Youth Survey – 2008*.

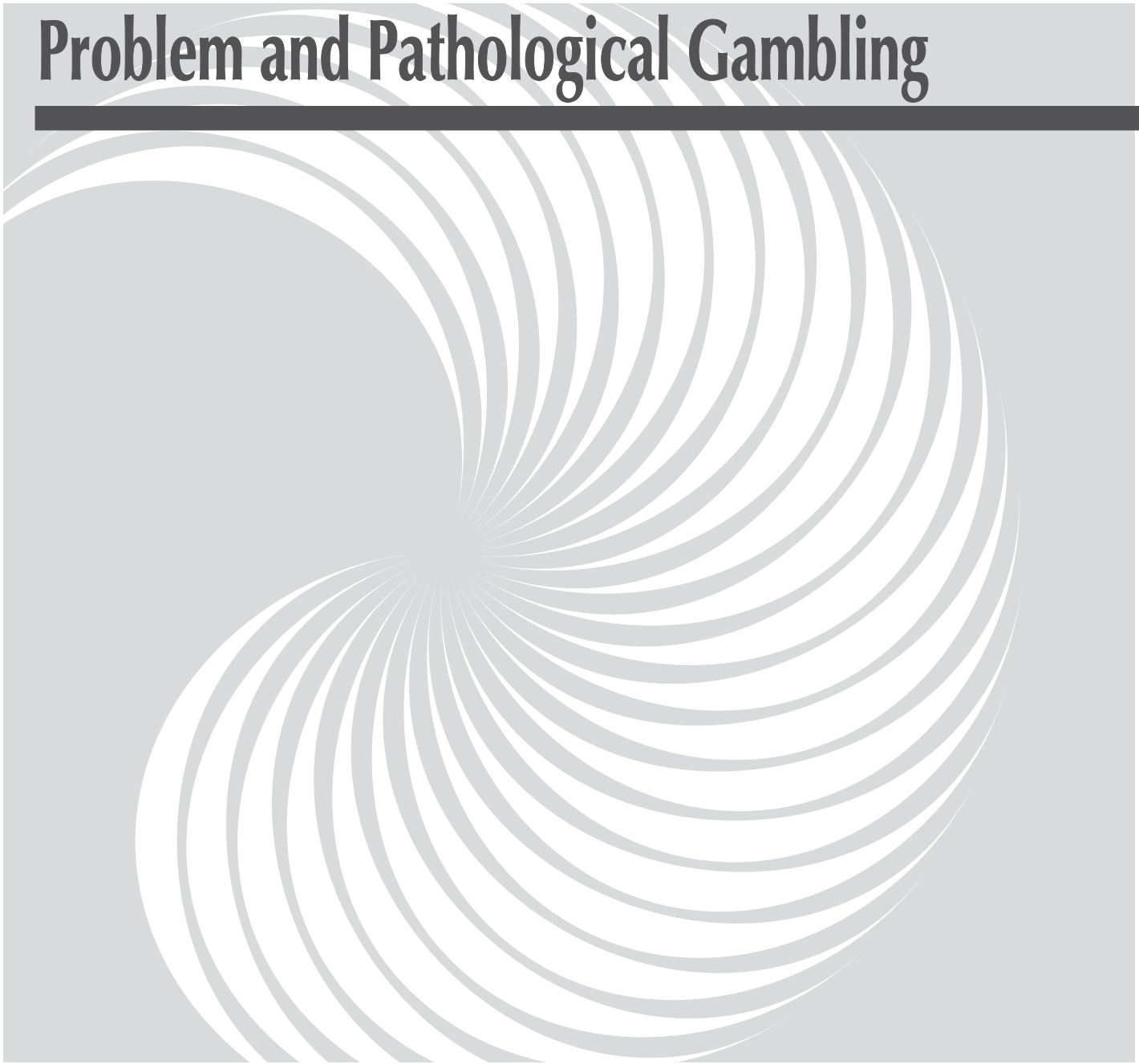
In 2008, 21.7% of Washington State 12th graders reported ever using prescription pain killers to get high, 12.0% in the past 30 days. Of these, more than half reported using them three or more times in the past 30 days. This represents 6.1% of all 12th graders, or almost 5,000 12th grade, in-school youth. Both the health risks and addiction potential of such use are extremely high.

Over the past decade, the expanded use of prescription-type opiates to treat pain has created new opportunities for diversion and illicit use, often resulting in addiction or death. Of those 12th graders who reported using prescription pain killers to get high at least once, 33% said they got them from friends, while 29% used their own prescriptions from a doctor or dentist.

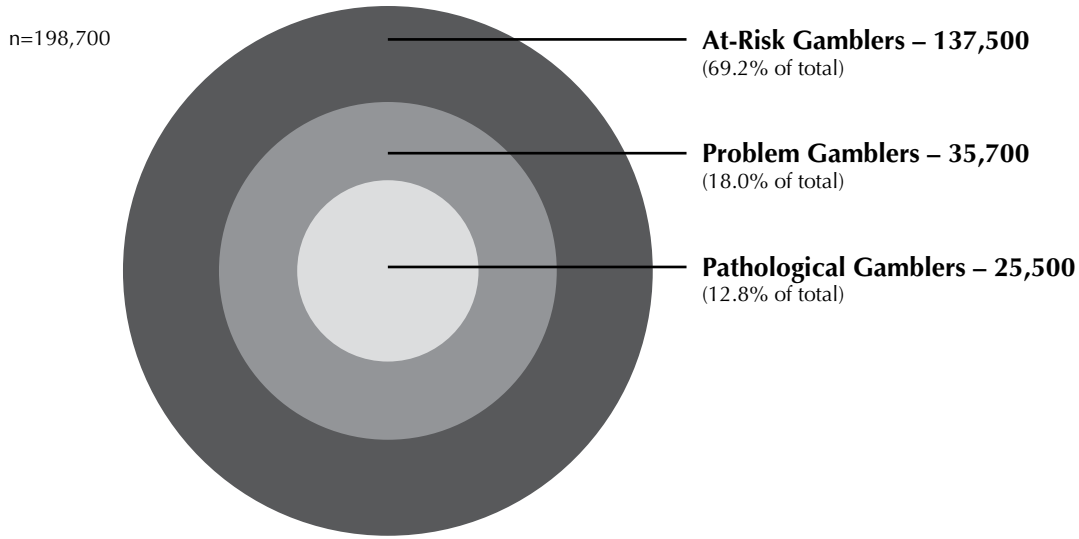


[1]Washington State Office of Superintendent of Public Instruction, Departments of Health, Social and Health Services, Community, Trade and Economic Development, Family Policy Council, and Liquor Control Board. *Healthy Youth Survey – 2008*. Olympia, WA: 2009.
[2]Ibid.

# Problem and Pathological Gambling



# In 2005, There were Almost 200,000 At-Risk, Problem, and Pathological Gamblers in Washington State.




Source: Research and Data Analysis Division, Washington State Department of Social and Health Services, *2003 Washington State Needs Assessment Household Survey (updated for 2005).*

It is estimated that approximately 7.2% of all adult gamblers in Washington State develop what the *Diagnostic and Statistical Manual - Fourth Edition* of the American Psychiatric Association defines as indicators of persistent and recurrent maladaptive gambling behavior. These are subdivided into a range from at-risk, to problem, to pathological gambling, based on the severity of symptoms.

In recognition of this problem, in 2005 the Washington State Legislature and Governor enacted legislation mandating a publicly funded program addressing the prevention and treatment of pathological gambling, to be administered by the Division of Alcohol and Substance Abuse. There is strong evidence of substantial comorbidity between pathological gambling and a range of substance abuse and mental health disorders. A 2005 study of comorbidity found that 73.2% of lifetime pathological gamblers had an alcohol use disorder; 38.1% a drug use disorder; and 60.4% were nicotine dependent.[1]



[1] Petry, N., Stinson, F., & Grant, B. "Comorbidity of DSM-IV Pathological Gambling and Psychiatric Disorders: Result form the National Epidemiologic Survey on Alcohol and Related Conditions," *Journal of Clinical Psychiatry* 66, 2005.

# The Problem Gambling Program

The Division of Behavioral Health and Recovery (DBHR) Problem Gambling Program was created by the Legislature and Governor in the 2005 Legislative Session. It is funded by a tax on net profits earned by public and private gambling enterprises, and is overseen by a 17-member advisory committee, including representatives of recovery and advocacy groups, gaming industry, state agencies, law enforcement, and Indian Tribes and tribal organizations. In its third year of operation, the Problem Gambling Program has implemented a strategic plan that provides for prevention of problem and pathological gambling, and intervention and treatment for individuals and families already struggling with problem and pathological gambling's negative impacts.

## *Prevention*

The program has launched campaigns to raise awareness about problem gambling. General posters and brochures in both English and Spanish have been designed and widely distributed. Materials target specific populations, including seniors, women with children, adolescent card players, and male college students have been distributed state wide.

A multi-year media campaign has invited youth and adults alike to visit the www.notagame.org website for comprehensive information about youth gambling. An advertisement developed for this media campaign won a Northwest Emmy Award. The award-winning ad can be viewed at the website. Interactive questions and answers, which are archived and can be read at any time, answer viewers' questions. Along with the television ad campaign, and the interactive website, billboards and bus posters were also used to remind the viewer of the television advertisements. Collateral electronic messaging is on You Tube and Meta Café.

The Problem Gambling Program is a participant in the planning and facilitation of the annual DBHR Prevention Summit, which targets high school youth and adults working in the youth prevention field.

## *Intervention*

Even though helpline calls have remained constant during the past year, the number of hits to both You Tube and Meta Café has consistently been rising each month, with over 96,000 hits on YouTube and over 21,700 hits on Meta Café during the past year. Those in need of problem gambling treatment have been finding it through the use of electronic means as well as use of the helpline. If a person needing assistance for problem gambling calls the helpline, the caller also receives a packet of information about problem gambling and referral to treatment services in the caller's area.

The State Council also trains casino workers to recognize signs that a patron may be in trouble with gambling, by recognizing signs of frustration, depression, or evidence that a patron is gambling more than s/he can afford. This training allows casino staff to make a brief intervention in a patron's gambling behavior. Individuals are given helpline referral information.

## Treatment

DBHR currently contracts with 25 agencies at 27 sites in 11 counties to provide assessment and treatment of problem and pathological gambling. Through June 2009, there have been 1,336 admissions to treatment since treatment was first offered in September 2005. Some 58% of clients treated for problem and pathological gambling are women, 73% of whom are over 40 years of age. Of the clients served in the program, approximately half are married, and 79% are Caucasian.

Youth can receive treatment at several agencies. However, only 1% of clients treated in 2008 were under age 21. Problem gambling treatment is available in Spanish at one site. Non-English speaking patients can receive treatment with the assistance of translator services at any publicly funded problem gambling treatment site.

Because the field of problem gambling treatment is so young, it is essential to build capacity and expertise among treatment providers. Toward that end, DBHR has contracted with the Evergreen Council on Problem Gambling to hold state conferences annualy since 2007. The conference has been well attended with participants not only from Washington, but from around the region and Canada.

During the current Biennium, the Problem Gambling Treatment Program is contracting with University of Washington for preliminary work with the ultimate goal of measuring program effectiveness. A literature search of assessment tools was completed. An initial survey of the current treatment providers was done, as well as literature review of treatment outcomes from other states. Analysis of TARGET data was used to demonstrate that most clients receiving problem gambling services had severe problems related to their gambling behaviors when admitted to treatment services. Challenges to analysis of treatment effectiveness include the fact that treatment completion is not standardized among providers. Treatment is not a standardized protocol using a particular workbook or standardized treatment sessions because each provider individualizes treatment on a case-by-case basis. Program evaluation will continue through the next biennium.

# Profile of Individuals Admitted to Publicly Funding Problem Gambling Treatment in Washington State

A profile of individuals admitted to publicly funded treatment in Washington State in SFY 2008 reveals the following characteristics at time of admission:[1]

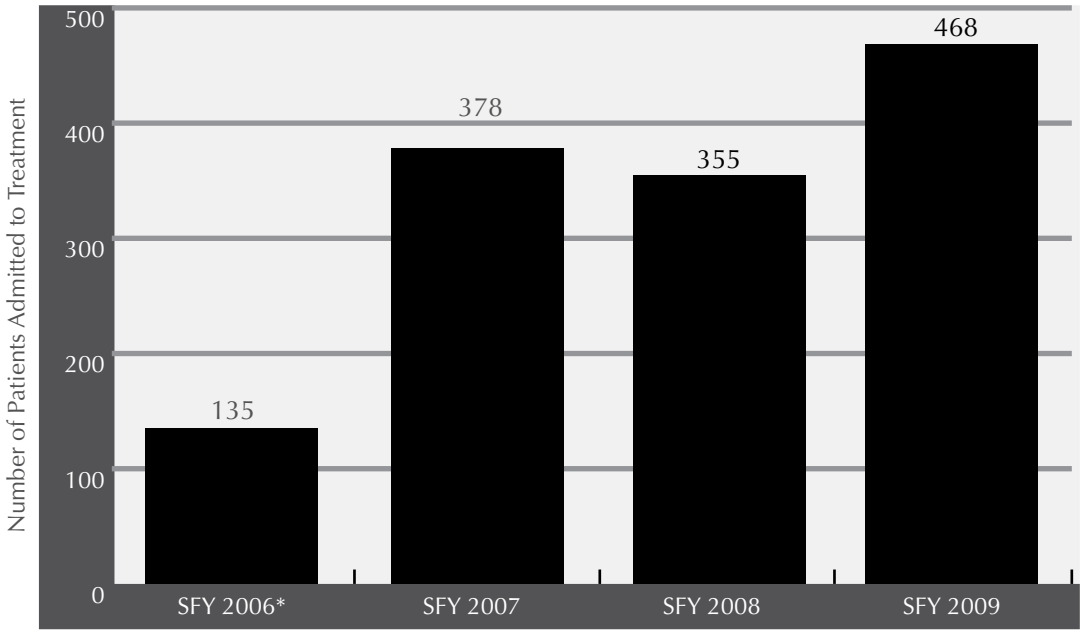
| | |
|---|---|
| *Number of Individuals Admitted:* | 321 |
| *Median Age:* | 46 |
| *Gender:* | 56% Female; 44% Male |
| *Race/Ethnicity:* | Caucasian - 81%; African-American - 2%; Asian/Pacific Islander - 10%; American Indian - 2%; Other/Multi-Race - 5%. Hispanic Origin - 4%. |
| *Employment Status:* | Employed (full- or part-time) - 64%; Unemployed - 36% |
| *Primary Drug:* | No Substance Abuse - 60%; Alcohol - 33%; Marijuana - 5%. |
| *% with Children in the Home:* | 32% |
| *% with Co-Occuring Disorder:* | 24% |
| *Housing Status:* | 20% homeless* |

** Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*



[1] Treatment and Assessment Report General Tool (TARGET), Division of Behavioral Health and Revovery, Washington State Department of Social and Health Services, November 2009. Data include unduplicated admissions to treatment.

# Since Its Inception, There Have Been More than 1,300 Admissions to the DBHR-Funded Problem Gambling Treatment Program.

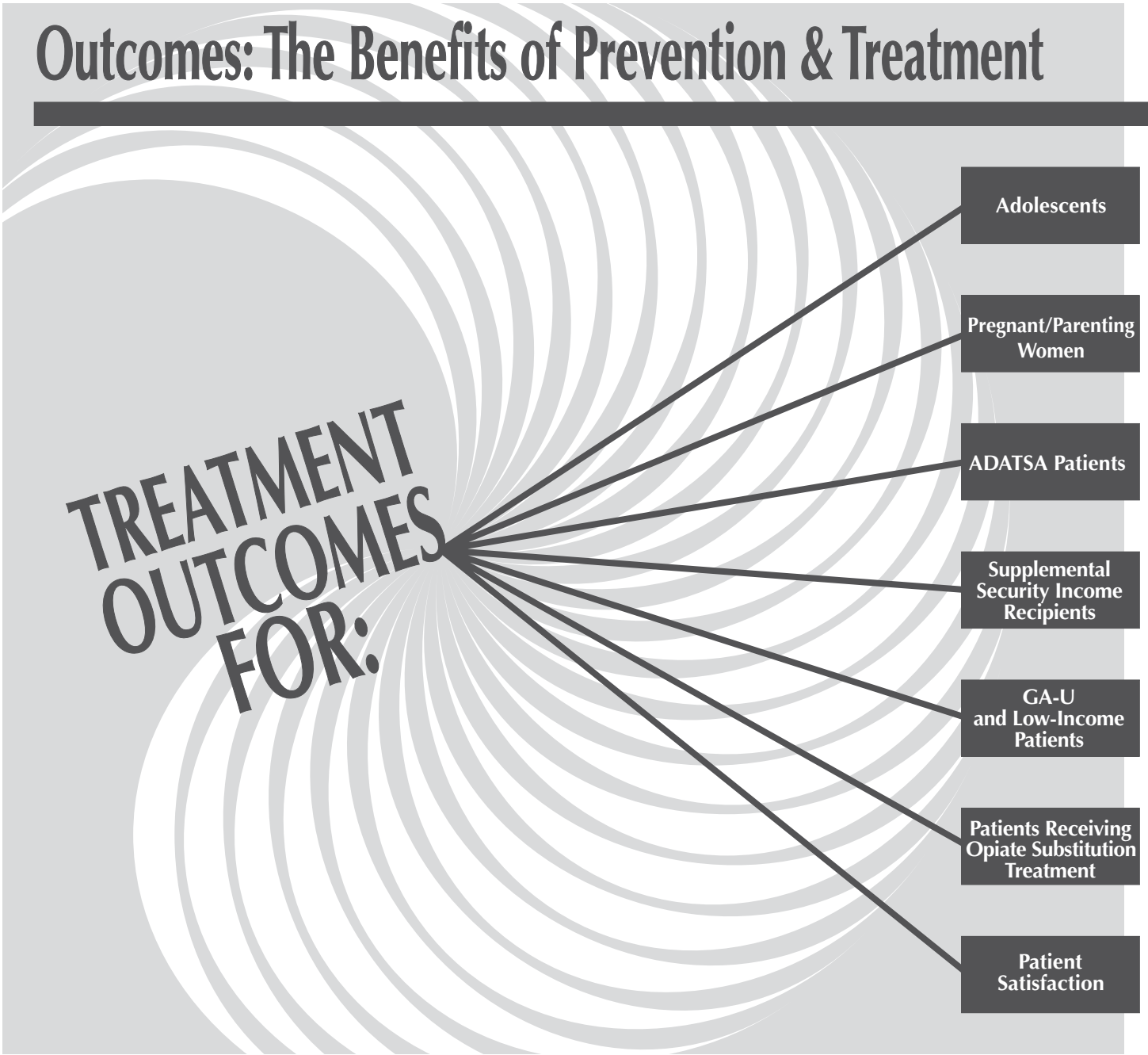



Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services.

The Division of Behavioral Health and Recovery currently contracts with 25 agencies at 27 sites in 11 counties to provide assessment and treatment of problem and pathological gambling. DBHR offers training to increase the number of counselors who can provide problem gambling treatment, and it is hoped that eventually treatment will be available statewide, The program is also supported by a Problem Gambling Hotline that refers callers to treatment agencies and through the 'Not-A-Game' website – www.notagame.org.

** First patients were admitted to treatment in September 2005.*

# Outcomes: The Benefits of Prevention & Treatment



# The Work of the DBHR Evaluation and Quality Assurance Section

The Division of Behavioral Health and Recovery (DBHR, formerly the Division of Alcohol and Substance Abuse) Evaluation and Quality Assurance Section was created to respond to the need to demonstrate the effectiveness of substance abuse prevention and treatment in serving the overall mission of the Department of Social and Health Services (DSHS) "to improve the quality of life for individuals and families in need." Through research and evaluation activities, DBHR is able to document the role of alcohol- and drug-related services in enhancing client self-sufficiency; protecting vulnerable adults, children, and families; assuring public safety; and helping to build strong, healthy communities. Research also aids in the development and implementation of "best practices" that can be utilized by chemical dependency treatment providers and substance abuse prevention providers; in improving the quality of care through the state; and in providing the scientific basis for the development of sound public policy.

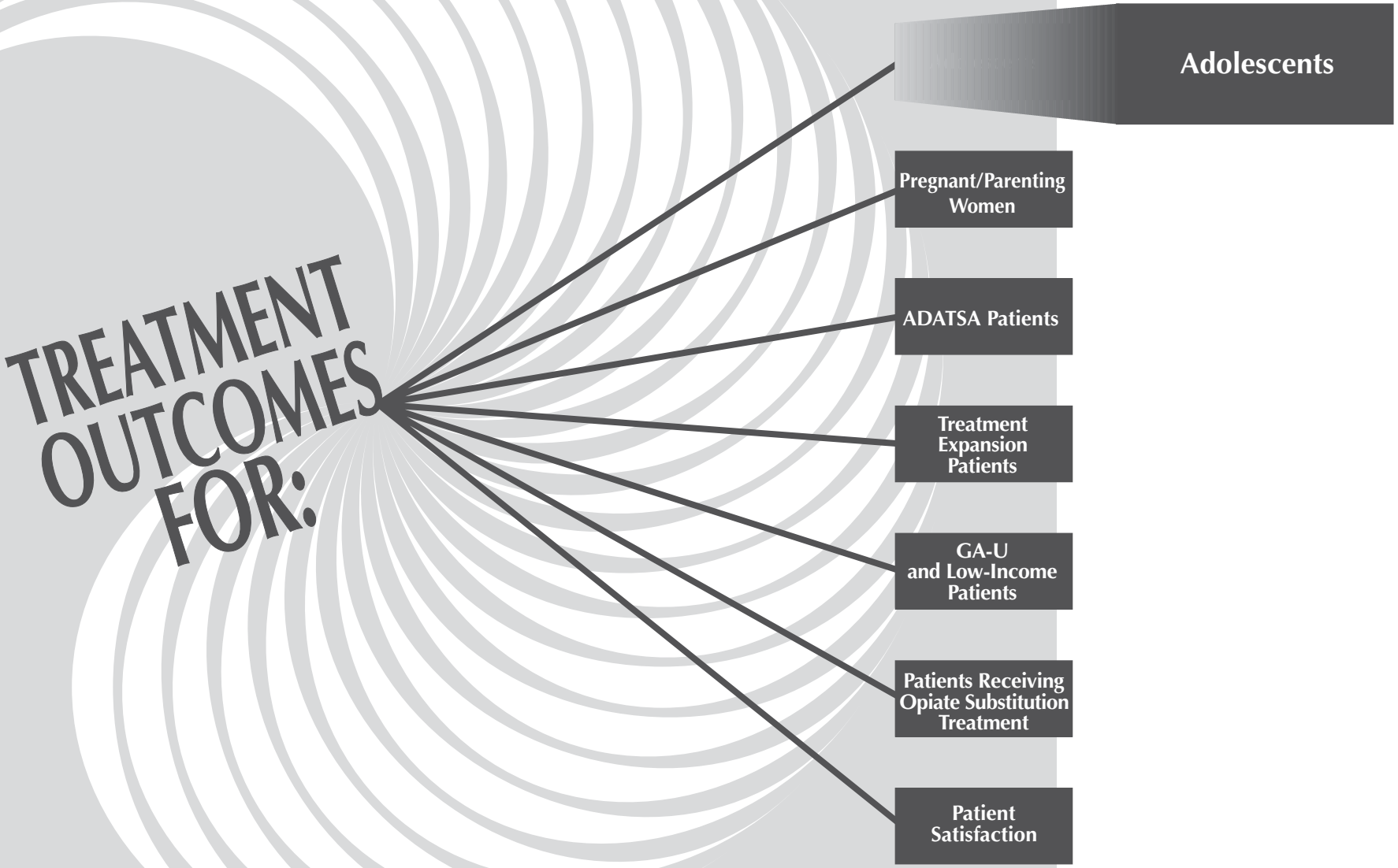
DBHR's productivity in research and evaluation is due, at least in part, to the strong partnerships it has developed with the research community for more than fifteen years. This is most evident in the 90-member Research Subcommittee of the Citizens Advisory Council on Alcoholism and Drug Addiction, which focuses on treatment issues. A new Prevention Research Subcommittee was formed in 2007. Members of both subcommittees are drawn from throughout the Northwest, including representatives of state universities, research institutions, state agencies, and the regional Addiction Technology Transfer Center (NF-ATTC).

## *Current Research Efforts*

Some of the results of the outcomes research conducted under the auspices of DBHR are displayed on the following pages. Below is a partial list of current research projects:

- Study of Medication-Assisted Chemical Dependency Treatment
- Study of the Network for the Improvement of Addiction Treatment (NIATx) Process Improvement Initiatives
- Study of Treatment Outcomes for Patients with Co-Occurring Disorders
- Study of the Use of Evidence-Based Practices in Treatment Programs
- Survey of Washington State Treatment Providers, Public and Private
- Survey of Patient Satisfaction at DBHR-Certified Treatment Agencies
- Evaluation of Problem Gambling Services

# Outcomes: The Benefits of Prevention & Treatment



# Profile of Adolescents Served in Publicly Funded Chemical Dependency Programs in Washington State

A profile of adolescents admitted to publicly funded treatment in Washington State in SFY 2008 reveals the following characteristics at time of admission:[1]

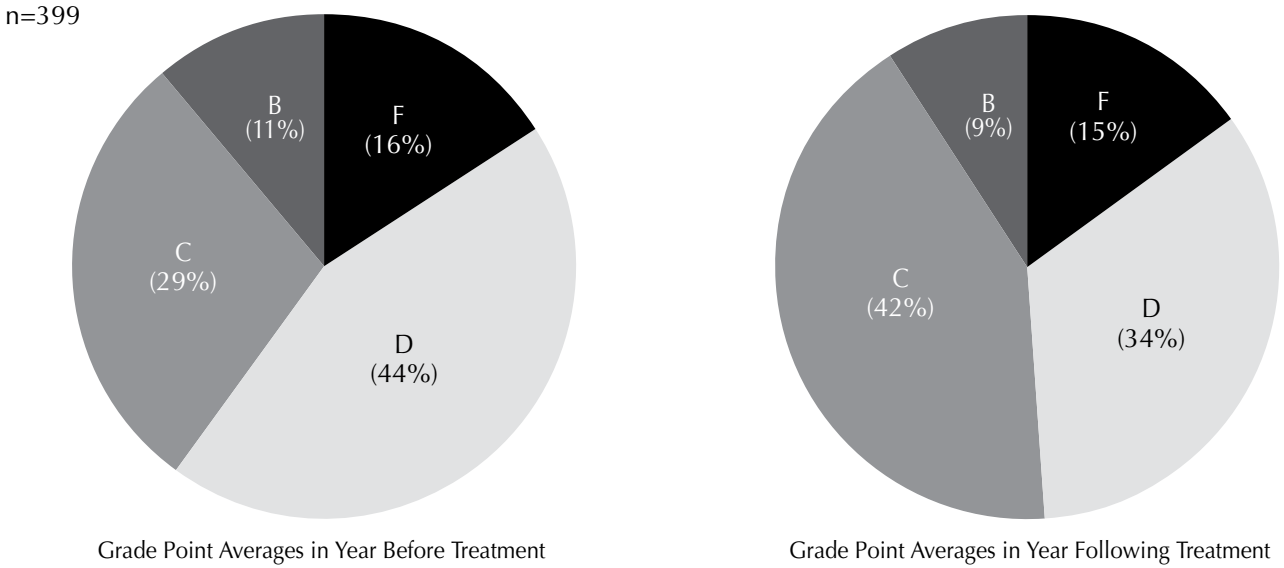
| | |
|---|---|
| *Number of Individuals Admitted:* | 5,194 |
| *Median Age:* | 16 |
| *Gender:* | 65% male; 35% female |
| *School Attendance:* | 66% in school (at least part-time); 34% out of school |
| *Primary Drug:* | Marijuana - 62%; Alcohol -25%; Methamphetamine - 4% |
| *% with Previous Admission:* | 22% |
| *Criminal Justice Involvement:* | 55% arrested at least once in previous year |
| *% with Co-Occurring Disorder:* | 25% with co-occurring mental health disorder |
| *Housing Status:* | 1% homeless* |

In SFY 2008, two-thirds of youth admitted to treatment had some involvement with the criminal justice system prior to admission. This included: 45% on probation or parole; 8% awaiting charges; 8% on diversion; and 5% involved with juvenile drug court.[2]

* *Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, November 2009. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.
[2] TARGET, 2009.

# High School Youth Ages 15-17 Who Receive and Complete Chemical Dependency Treatment See Their Grades Improve Compared to the Year Before Treatment.




Grade Point Averages in Year Before Treatment

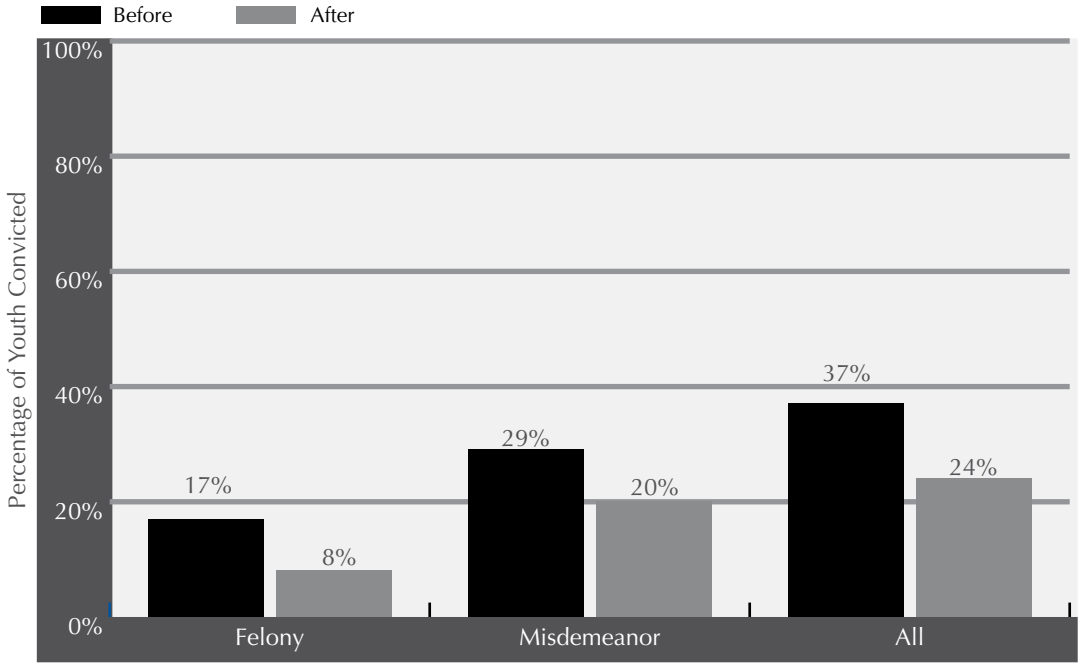
Grade Point Averages in Year Following Treatment

Source: Longhi, D., and Felver, B., "School Enrollment, School Retention, and Grades Improve Among Youth Who Complete and/or Stay Longer in Alcohol and Other Drug (AOD) Treatment." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, December 2005.

Chemical dependency treatment is associated with better outcomes for school-age youth in need of treatment, including lower rates of delinquent behavior, felonies and misdemeanors, and legal supervision. It is also associated with improved school outcomes, including lower school dropout rates.

These graphs indicate that full-time students who complete chemical dependency treatment demonstrate better school performance in the year following treatment, compared with the year before. The percentage of students with grade point averages of "C" or better increased from 40% to 51%, representing a 27.5% increase.

# There are Significant Declines in Criminal Convictions Among Youth Who Receive Chemical Dependency Treatment.

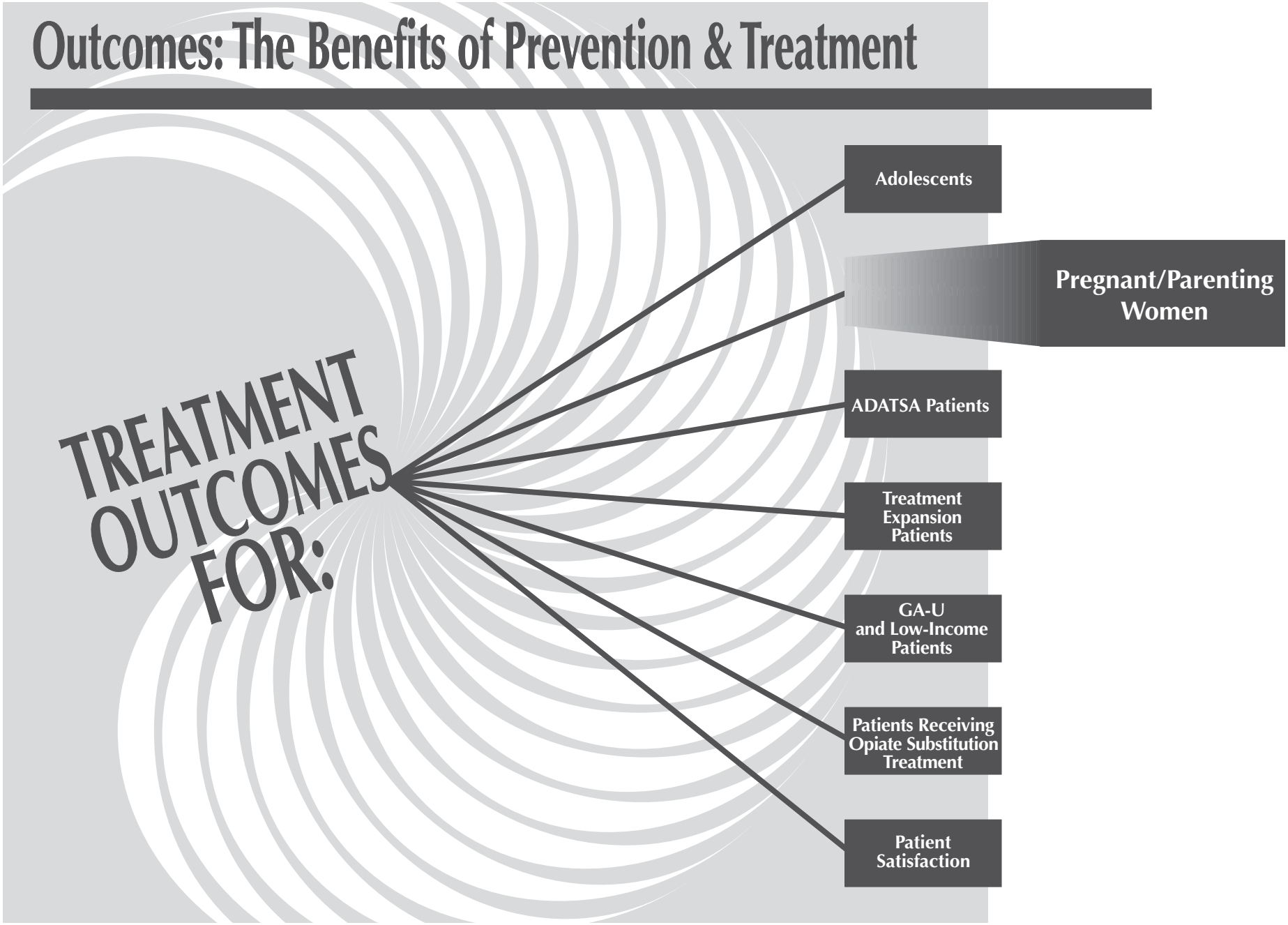



Source: Luchansky, B., et al., "Treatment Readmissions and Criminal Recidivism in Youth Following Participation in Chemical Dependency Treatment," *Journal of Addictive Diseases 25*(1), 2006.

A 2003 study of almost 6,000 Washington State youth ages 14-17 found significant declines in criminal convictions following chemical dependency treatment. The rate of all convictions fell from 37% in the 18 months prior to treatment to 24% in the 18 months following treatment, representing a 35% decline. Felony convictions declined by 56%; misdemeanors fell by 30%.

Significant strides have been made in recent years in ensuring more timely access to publicly funded chemical dependency treatment for youth.

# Outcomes: The Benefits of Prevention & Treatment



# Profile of Pregnant/Parenting Women* Served in Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of pregnant/parenting women admitted to publicly funded treatment in Washington State in SFY 2008 reveals the following characteristics at time of admission:[1]

| | |
|---|---|
| *Number of Individuals Admitted:* | 1,473 |
| *Median Age:* | 27 |
| *Employment Status:* | Employed (full- or part-time) – 12%; Unemployed – 82% |
| *Primary Drug:* | Methamphetamine - 31%; Alcohol – 27%; Marijuana - 15%; Prescription-type Opiates - 11% |
| *% with Previous Admission:* | 52% |
| *Criminal Justice Involvement:* | 54% arrested at least once in previous year |
| *% with Children in the Home:* | 48% |
| *% with Co-Occurring Disorder:* | 37% with co-occurring mental health disorder |
| *Housing Status:* | 11% homeless** |

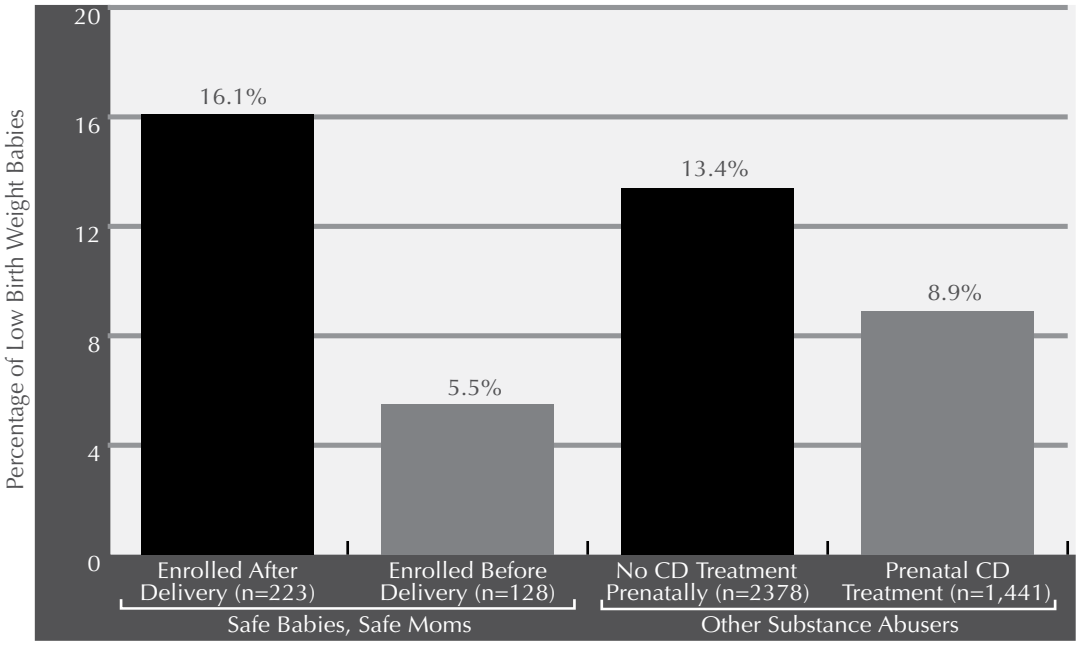
In SFY 2008, of the 1,473 PPWs admitted to chemical dependency treatment funded by the Division of Alcohol and Substance Abuse:

- Some 37% had a co-occurring mental health disorder, and 25% received mental health treatment in the year prior to admission.
- More than 10% reported prescription-type opiates as their primary substance of abuse.
- 60% had a past history of being victims of domestic violence.
- 64% listed public assistance as their source of income at time of admission.[2]

**Pregnant/parenting women are defined as those whose contract type at time of admission was "PPW", or whose estimated pregnancy due date falls within the treatment episode (i.e. either within 90 days prior to, or with 280 days following treatment admission.)*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, November 2009. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.
[2] Rodriquez, F., *Profile of Pregnant, Post-Partum, and/or Parenting Women (PPWs) Admitted to Publicly Funded Substance Abuse Treatment Programs in Washington State, 1998.* Olympia, WA: Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 1999.

# Substance-Abusing Women Who Received Chemical Dependency Treatment were Less Likely to Have a Low Birth Weight Baby.



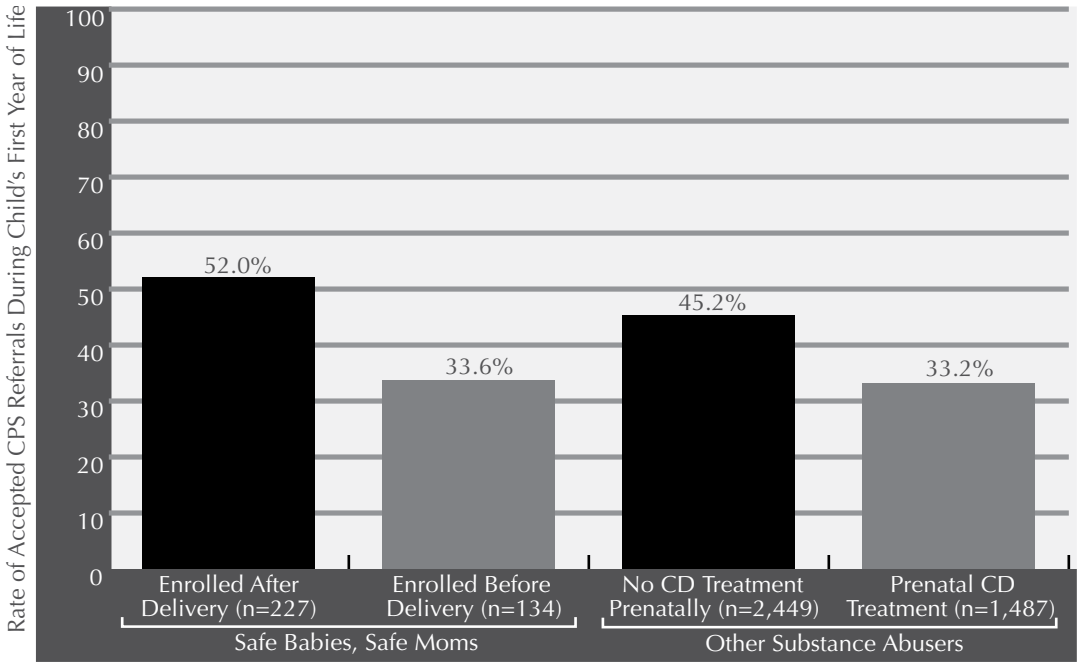

Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Low birth weight (LBW) – newborn infants weighing less than 5.5 pounds, or 2,500 grams—is the risk factor most closely associated with neonatal death, and is associated with a wide range of disorders, including neurodevelopmental conditions, mental retardation, vision and hearing impairments, and other developmental disabilities. Alcohol and other drug abuse is linked to LBW.[1]

Substance-abusing pregnant mothers receiving comprehensive services, including chemical dependency treatment, through the Safe Babies, Safe Moms program, were 66% less likely to give birth to a LBW baby, compared with substance-abusing women who enroll after delivery. Outside of the program, substance-abusing women who received chemical dependency treatment prenatally were 34% less likely to give birth to a LBW baby, compared with women who did not receive treatment.[2]

[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4, 5, 34. Washington, DC: 2000.
[2] Cawthon, L, "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

# Substance-Abusing Women Who Received Chemical Dependency Treatment Prenatally were Less Likely to Be Referred Later to Child Protective Services.



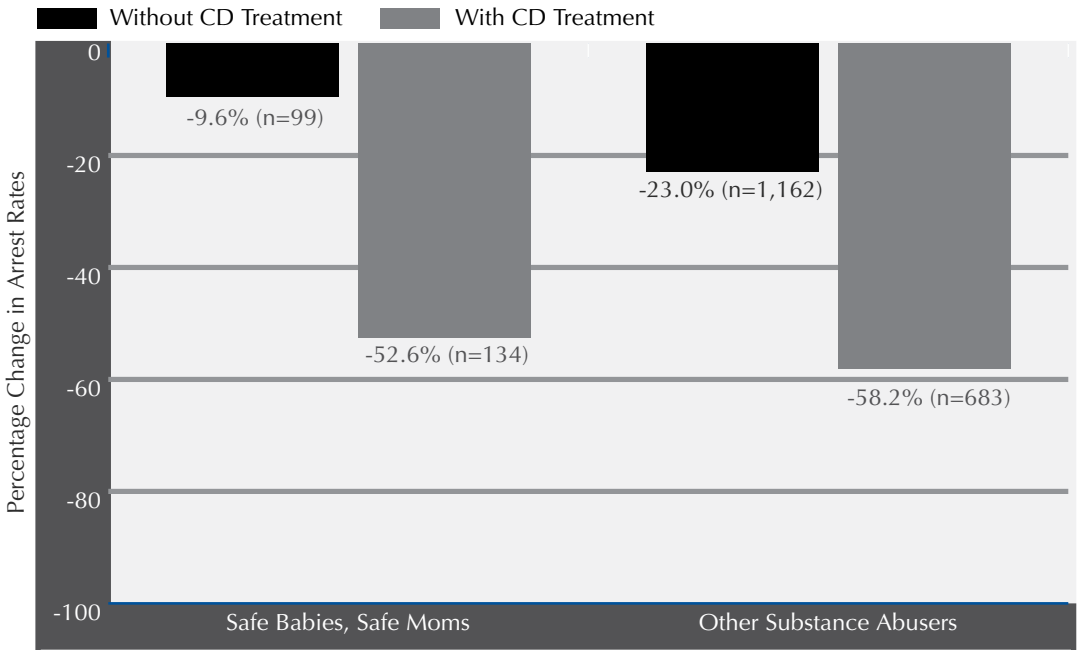

Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

Child abuse and neglect is one of the most important consequences of maternal substance abuse. The rate of accepted referrals to Child Protective Services (CPS) during a child's first year of life is ten times higher (45.2%) when their substance-abusing mothers did not receive chemical dependency treatment than for infants on Medicaid whose mothers are not substance abusers (4.5%).

Substance-abusing pregnant mothers receiving comprehensive services, including chemical dependency treatment prenatally, through the Safe Babies, Safe Moms program, were 35.4% less likely to be referred to CPS during the first year of their child's life than those enrolling after their child was born. Outside of the program, substance-abusing women who received chemical dependency treatment prenatally were 26.5% less likely to be referred to CPS during the first year of their child's life than substance-abusing women who did not receive treatment.[1]

[1] Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

# Substance-Abusing Pregnant Women Who Received Chemical Dependency Treatment were Less Likely to Be Arrested.




Source: Cawthon, L., "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

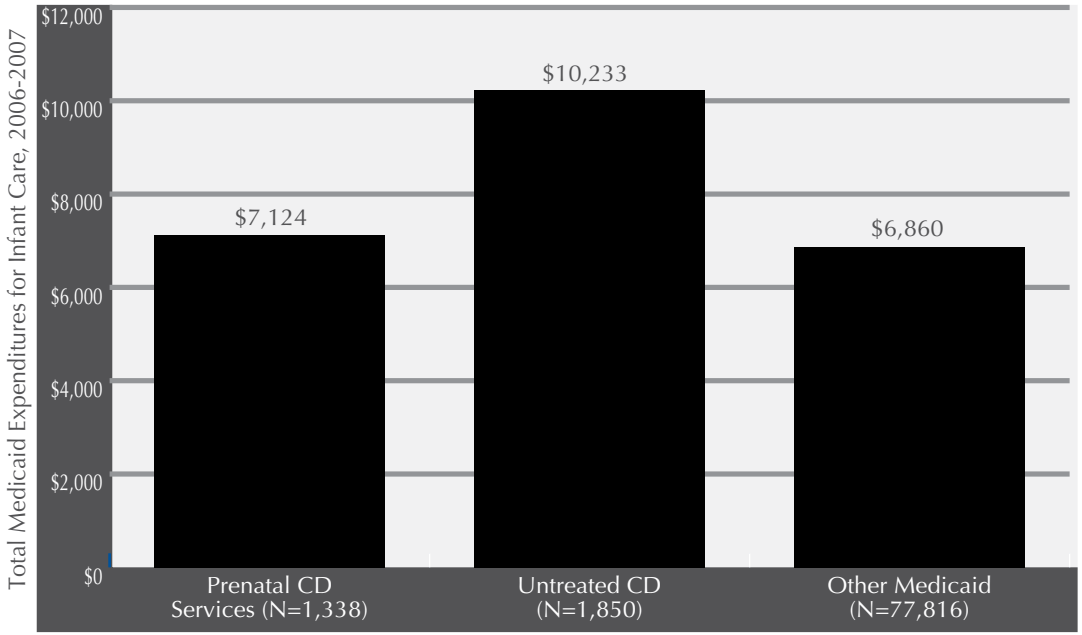
Criminal justice involvement is a significant issue for many pregnant, substance-abusing women. In addition to the burden of drug- and alcohol-related crime on society, crime presents serious health and developmental risks to children, both prenatally and after they are born.

Among women enrolled in the Safe Babies, Safe Moms program, those who received chemical dependency treatment had more than a five times greater reduction in arrest rates in the following two years compared with those who did not receive treatment. Outside of the program, among substance-abusing pregnant women, those who received chemical dependency treatment had more than double the reduction in arrest rates in the following two years after delivery compared with those who did not receive treatment.[1]



[1] Cawthon, L. "Safe Babies, Safe Moms" (Fact Sheet Number 4.36f). Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, January 2004.

# Average Medicaid Costs During the First Year of Life were Lower for Infants Born to Women Who Received Chemical Dependency Treatment in the Prenatal Period than for Those Born to Substance-Abusing Women Who Did Not Receive Treatment.




Source: First Steps Database, Research and Data Analysis Division, Washington State Department of Social and Health Services, 2009.

Low birth weight (LBW – newborn infants weighing less than 5.5 pounds, or 2,500 grams) is the single most important factor in determining infant medical care expenditures during the neonatal period. Alcohol and other drug use is associated with LBW.[1]

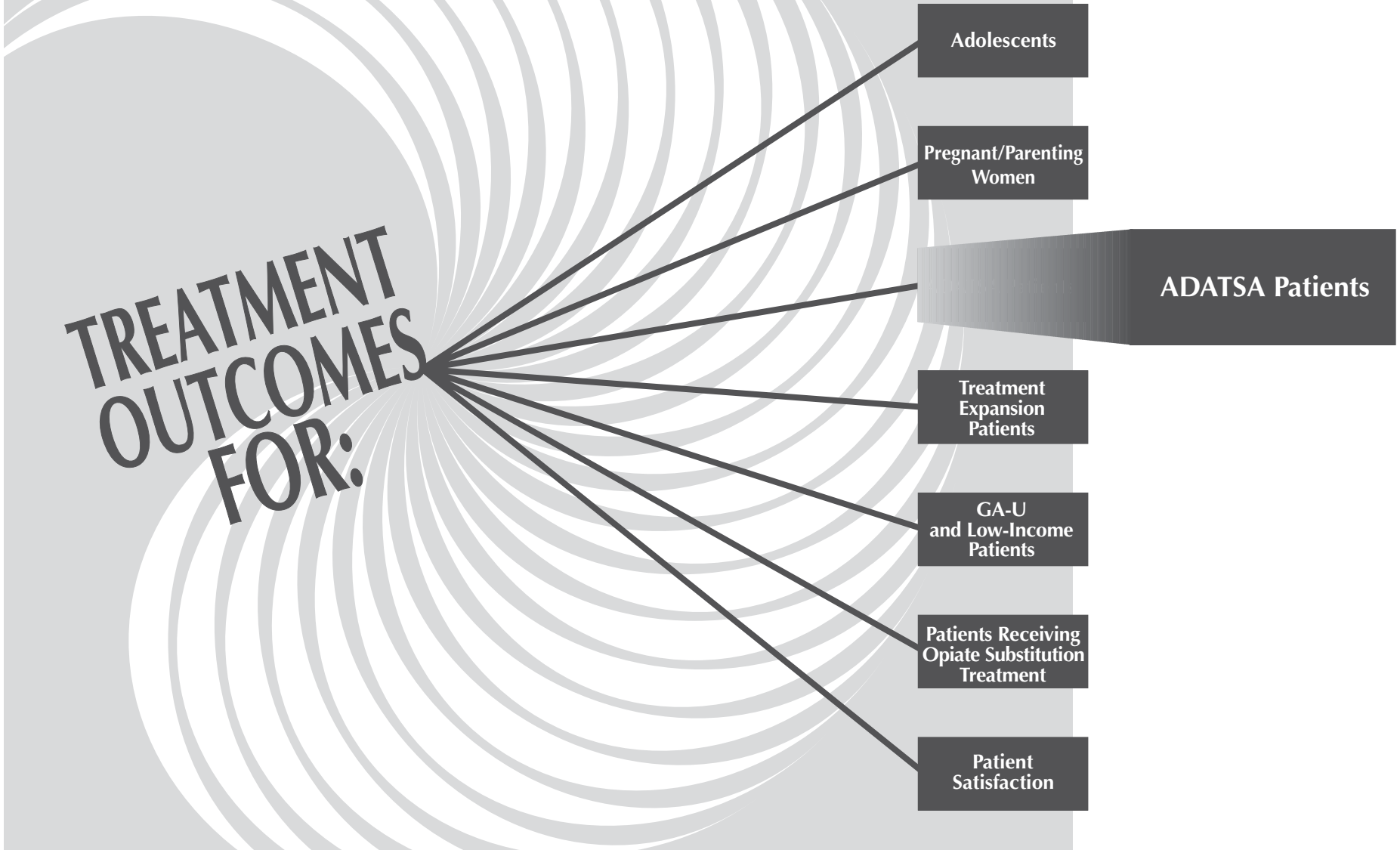
This graph indicates that average Medicaid expenditures for care during the first year of life for infants born to untreated substance abusers was 43.6% higher than for substance-abusing women who received chemical dependency treatment during pregnancy, and 49% higher than that for infants born to non-substance abusing women receiving Medicaid.





[1] U.S. Department of Health and Human Services. *Healthy People 2010* (Conference Edition), 16-4, 5, 34. Washington, DC: 2000.

# Outcomes: The Benefits of Prevention & Treatment



# Profile of ADATSA Patients Receiving Publicly Funded Chemical Dependency Treatment in Washington State

A profile of patients admitted to publicly funded treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) in Washington State in SFY 2008 reveals the following characteristics at time of admission:[1]

| | |
|---|---|
| *Number of Individuals Admitted:* | 7,971 |
| *Median Age:* | 34 |
| *Gender:* | 70% Male; 30% Female |
| *Employment Status:* | Employed (full- or part-time or temporary) – 6%; Unemployed – 94% |
| *Primary Drug:* | Alcohol – 39%; Methamphetamine – 24%; Cocaine/Crack – 11%; Marijuana - 10% |
| *% with Previous Admission:* | 61% |
| *Criminal Justice Involvement:* | 62% arrested at least once in previous year |
| *% with Children in the Home:* | 8% |
| *% with Co-Occurring Disorder:* | 19% with co-occurring mental health disorder |
| *Housing Status:* | 24% homeless* |

Enacted in 1987, the ADATSA legislation created a program to treat adults addicted to alcohol or other drugs. To qualify, clients must be indigent, unemployable, and incapacitated due to their addiction. Patients may be admitted to either residential or outpatient treatment modalities as individually required. The immediate goal of the program is abstinence, while ancillary goals include improved personal coping skills, as well as social and vocational skills. Success is expected to result in patients moving toward a long-term objective of self-sufficiency.

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, November 2009. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

# Average Medical Costs for ADATSA Clients Who Received Chemical Dependency Treatment were 29% Lower in the Year Following Enrollment than for Clients Who were Untreated.

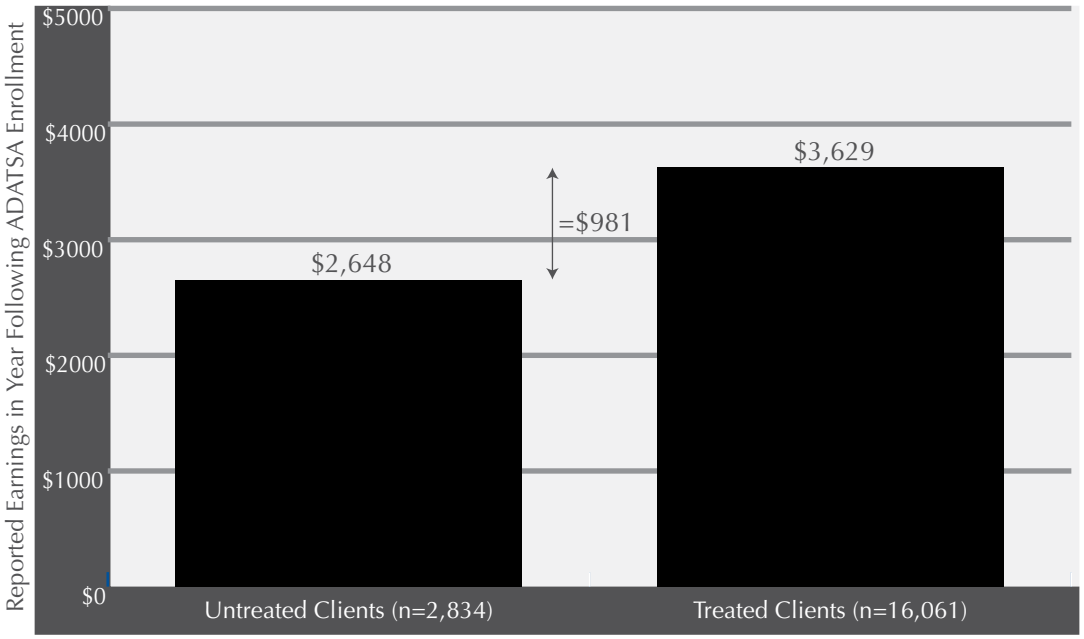

Source: Mancuso, D., et al., *Treatment Works! For ADATSA Clients, Report 4.67*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2008.

Under the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), individuals who are disabled and unable to work due to an alcohol or drug disorder may qualify for assessments, chemical dependency treatment, and financial support. A study of ADATSA-eligible clients in SFY 2002-2004 found that clients who received chemical dependency treatment and were subsequently eligible for Medicaid had medical costs that were 29% lower in the year following enrollment than those who did not receive treatment. The savings in the year following enrollment totaled $2,868, more than the average $2,629 cost of providing treatment.[1] There were likely subsequent savings in future years.



[1] Mancuso, D., et al. *Treatment Works! For ADATSA Clients, Report 4.67*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2008.

# ADATSA Clients Who Received Chemical Dependency Treatment Earned 37% More in the Year Following Enrollment than Clients Who were Untreated.




Source: Mancuso, D., et al., *Treatment Works! For ADATSA Clients, Report 4.67*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2008.

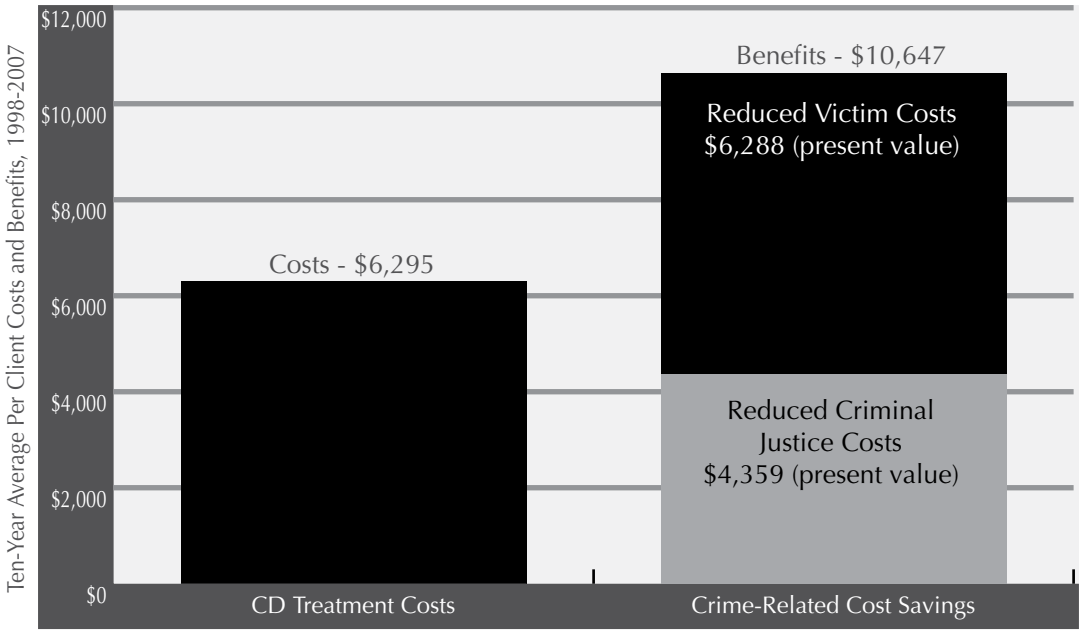
Under the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), individuals who are disabled and unable to work due to an alcohol or drug disorder may qualify for assessments, chemical dependency treatment, and financial support. A study of ADATSA-eligible clients in SFY 2002-2004 found that clients who received chemical dependency treatment earned 37% more in the year following enrollment than those who did not. Some 51% of treated clients had earnings recorded in Employment Security Department wage data, compared to 39% of untreated clients.

Criminal recidivism was also 32% lower among ADATSA clients with a prior arrest who received treatment than those who did not.[1]

[1] Mancuso, D., et al. *Treatment Works! For ADATSA Clients, Report 4.67*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2008.

NEW/CHANGING TREND

# Providing Chemical Dependency Treatment to ADATSA Clients Results in Significantly Reduced Costs to Crime Victims and the Criminal Justice System.




Source: Mancuso, D., and Felver, B., *Chemical Dependency Treatment, Public Safety Implications for Arrest Rates, Victims and Community Protection – Report 11.140*. Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2009.

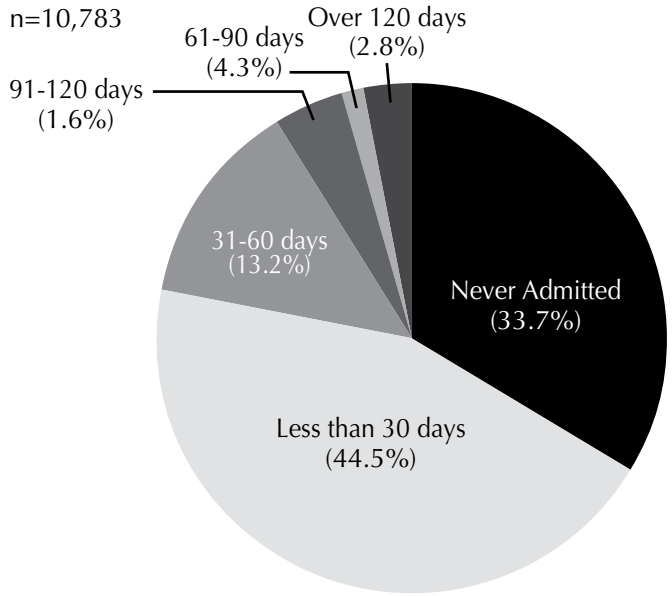
In 2006, individuals who received chemical dependency treatment under the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA) experienced an 18% decline in the number of arrests per client in the following year compared with ADATSA clients who did not receive treatment. Although clients may engage in treatment over a number of years, the 10-year crime-related cost savings, even accounting for the cost of treatment, were $4,352. The present total value of crime-related cost savings were $101 million in 2006. This is in addition to costs savings resulting from reduced medical care and hospitalization, higher rates of employment, and worker productivity.[1]



[1] Mancuso, D., and Felver, B. *Chemical Dependency Treatment, Public Safety Implications for Arrest Rates, Victims and Community Protection – Report 11.140*. Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2009.

# More than Half of Individuals Assessed as in Need of, and Who Qualify for Chemical Dependency Treatment Under ADATSA Receive Treatment Within 60 Days.

## *ADATSA Wait Time for Individuals Assessed During FY 2008*

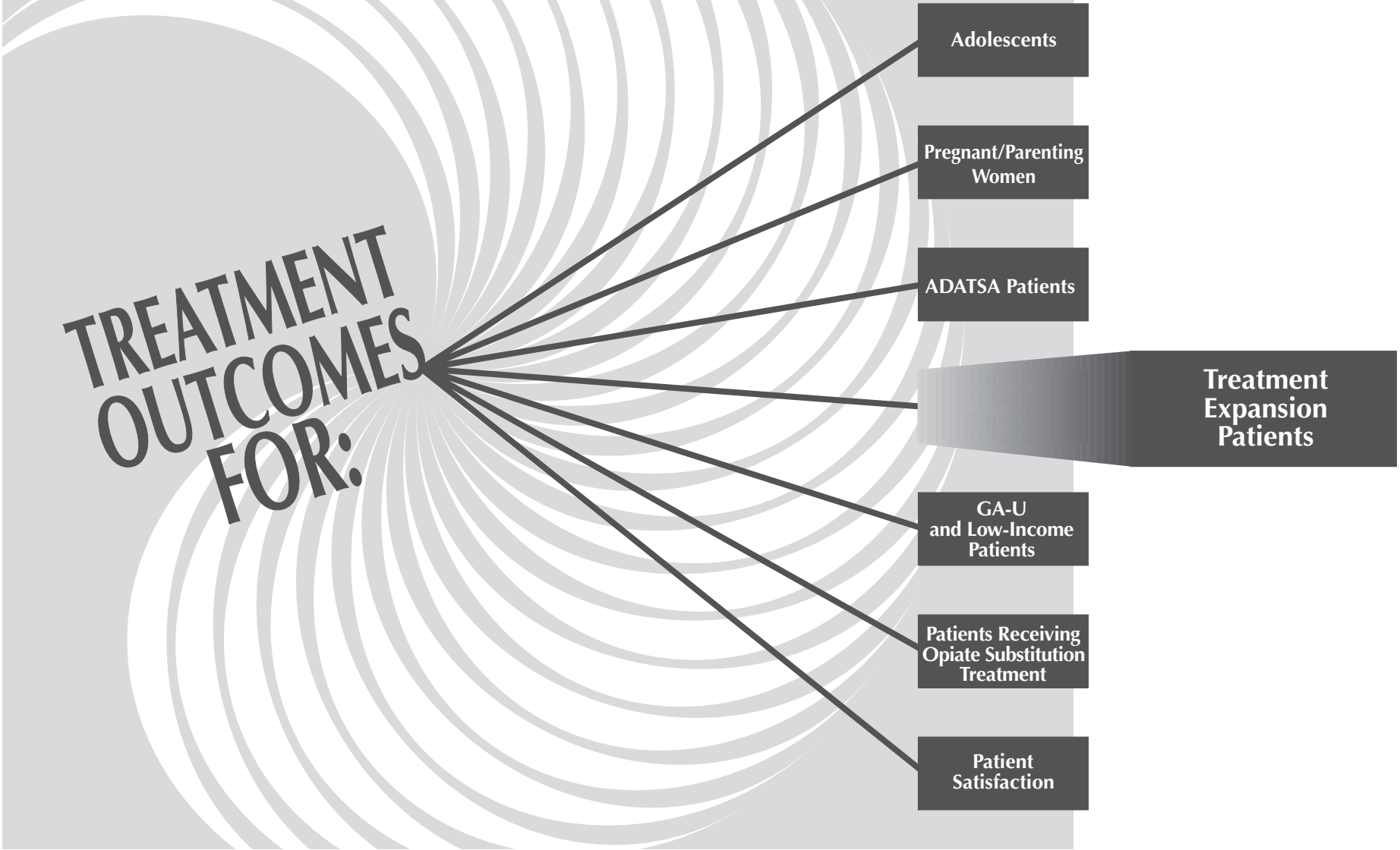



Source: Treatment and Report Generation Tool (TARGET), Washington State Department of Social and Health Services, Division of Alcohol and Substance Abuse, 2009.

Under the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), individual who are disabled and unable to work due to an alcohol or drug disorder may qualify for assessments, chemical dependency treatment, and financial support. While approximately a third of those assessed as in need are never admitted into treatment under ADATSA, many such individuals may be admitted to treatment under another payment source. Reducing wait times between first requests for service and treatment admissions has been demonstrated to result in significantly improved patient retention.[1]

[1] McCarty, D., et al. "The Network for the Improvement of Addiction Treatment (NIATx): Enhancing Access and Retention." *Drug and Alcohol Dependence* 88(2,3), 2007; Wisdom, J., et al. "Addiction Treatment Agencies' Use of Data: A Qualitative Assessment." *Journal of Behavioral Health Services and Research* 33(4), 2006.

# Outcomes: The Benefits of Prevention & Treatment



# Profile of Adult Treatment Expansion Patients Receiving Chemical Dependency Treatment in Washington State

In 2005, the Legislature and Governor enacted the Omnibus Mental Health and Substance Abuse Disorders Treatment Act. The Act expanded funding for alcohol and drug treatment for adults on Medicaid or receiving General Assistance, and for low-income youth. The adult expansion was funded through assumed savings in medical and long-term care costs, based on the results of earlier pilot projects providing chemical dependency treatment to Supplemental Security Income (SSI) recipients.

A profile of adult patients in the Treatment Expansion categories admitted to publicly funded treatment in Washington State in SFY 2008 reveals the following characteristics at time of admission:[1]

| | |
|---|---|
| *Number of Individuals Admitted:* | 13,162 |
| *Median Age:* | 36 |
| *Gender:* | 46% Male; 54% Female |
| *Employment Status:* | Employed (full- or part-time) – 10%; Unemployed – 90% |
| *Primary Drug:* | Alcohol – 39%; Methamphetamine – 17%; Marijuana – 14%; Cocaine – 11% |
| *Criminal Justice Involvement:* | 55% arrested at least once in previous year |
| *% with Children in the Home:* | 45% |
| *% with Co-Occurring Disorder:* | 45% with co-occurring mental health disorder |
| *Housing Status:* | 13% homeless* |

As a result of Treatment Expansion:

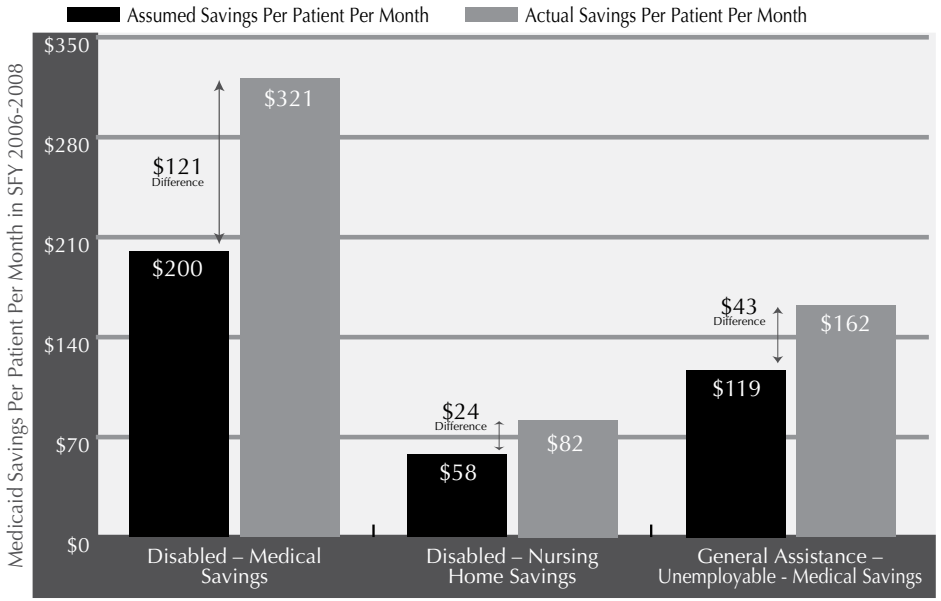
- The number of Medicaid Disabled clients receiving chemical dependency treatment increased from 7,960 patients in SFY 2005, to 10,915 in SFY 2008, representing a 37.1% increase.
- The number of General Assistance-Unemployable clients receiving chemical dependency treatment rose from 1,660 in SFY 2005, to 2,923 in SFY 2008, representing a 76.1% increase.
- The number of other adults on Medicaid (including those receiving Temporary Assistance for Needy Families) who received chemical dependency treatment rose from 8,634 in SFY 2005, to 9,768 SFY 2008, representing a 13.1% increase.[1]

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Mancuso, D., Nordlund, D., and Felver, B. *DASA Treatment Expansion: Spring 2009 Update – Report 4.75.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, June 2009.

NEW/CHANGING TREND

# In SFY 2006-2008, Medical Savings for Individuals Receiving Chemical Dependency Treatment as a Result of Treatment Expansion were Far Greater than Anticipated.




Source: Mancuso, D., et al., *DASA Treatment Expansion: Spring 2009 Update – Report 4.75.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2009.

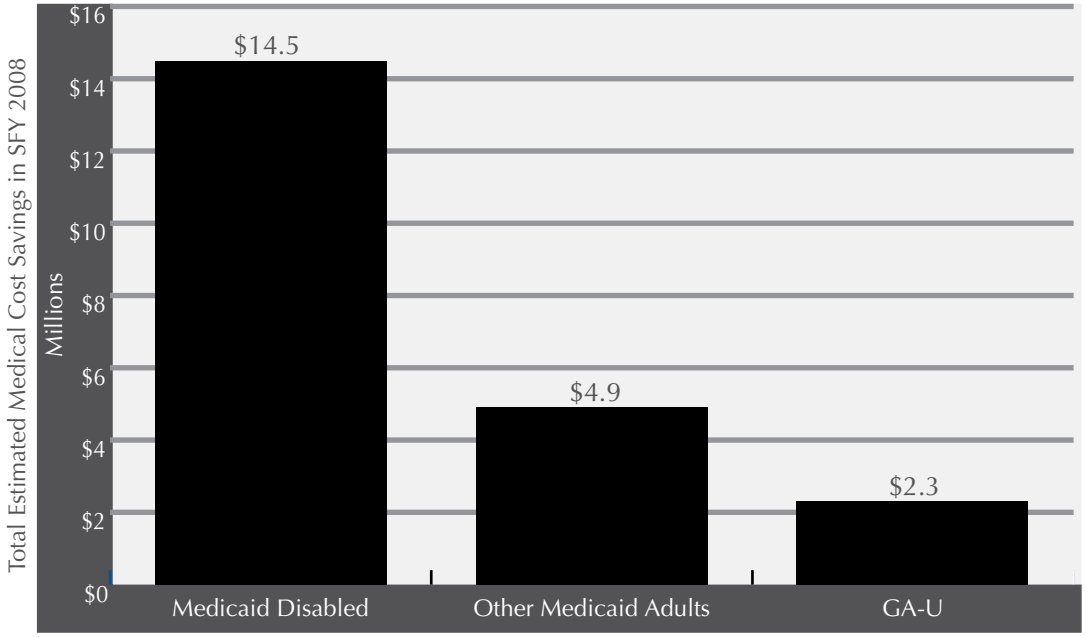
In 2005, the Legislature and Governor enacted the Omnibus Mental Health and Substance Abuse Disorders Treatment Act. The Act expanded funding for alcohol and drug treatment for adults on Medicaid or receiving General Assistance, and for low-income youth. The adult expansion was funded through assumed savings in medical and long-term care costs, based on the results of earlier pilot projects providing chemical dependency treatment to Supplemental Security Income (SSI) recipients.

While the ramp-up in providing treatment to qualified clients was slower than anticipated, the graph above indicates that per patient per month savings resulting from access to chemical dependency treatment were significantly higher than expected. Total estimated medical savings in the SFY 2008 Biennium were $21.7 million.[1]



[1] Mancuso, D., et al. *DASA Treatment Expansion: Spring 2009 Update – Report 4.75.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2009.

# In SFY 2008, Total Medical Savings for Treatment Expansion Patients Receiving Chemical Dependency Treatment was $21.7 Million.




Source: Mancuso, D., et al., *DASA Treatment Expansion: Spring 2009 Update – Report 4.75.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2009.

Enacted in 2005, the Omnibus Treatment of Mental and Substance Abuse Disorders Act provided expanded funding ("treatment expansion") for treatment of substance abuse disorders. The adult expansion targeted individuals receiving Medicaid and General Assistance, and was funded by primarily by assumed savings in medical and long-term costs. In SFY 2008, the medical costs savings resulting from treatment expansion ($21.7 million) was significantly greater than the adult treatment expansion appropriation ($17.3 million).[1]

Other likely significant savings resulting from treatment expansion include: fewer criminal arrests, and decreases in crime and criminal justice costs; decrease in social service costs, including those related to child abuse and neglect; and lower public assistance costs due to increased employment and earnings.



[1] Mancuso, D., et al. *DASA Treatment Expansion: Spring 2009 Update – Report 4.75.* Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2009.

# Profile of Supplemental Security Income (SSI) Recipients Receiving Publicly Funded Chemical Dependency Treatment in Washington State

Under the Supplemental Security Income (SSI) program, the federal government provides public assistance to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.

A profile of SSI recipients admitted to publicly funded chemical dependency treatment in Washington State in SFY 2008 reveals the following characteristics at time of admission:[1]

| | |
|---|---|
| *Number of Individuals Admitted:* | 2,987 |
| *Median Age:* | 43 |
| *Gender:* | 56% Male; 44% Female |
| *Employment Status:* | Employed (full- or part-time or temporary) – 4%; Unemployed – 96% |
| *Primary Drug:* | Alcohol – 42%; Methamphetamine – 13%; Cocaine – 13%; Heroin – 13% |
| *% with Previous Admission:* | 57% |
| *Criminal Justice Involvement:* | 53% arrested at least once in previous year |
| *% with Children in the Home:* | 14% |
| *% with Co-Occurring Disorders:* | 56% with co-occurring mental health disorder |
| *Housing Status:* | 15% homeless* |

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

As a result of the Omnibus Mental Health and Substance Abuse Treatment Act enacted by the Legislature in 2005, DASA substantially expanded treatment access to Medicaid-eligible individuals, including those receiving SSI.



[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, November 2009. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.

# Chemical Dependency Treatment Lowers Medical Costs and is Associated with Better Criminal Justice Outcomes Among Supplemental Security Income (SSI) Recipients.*

The Department of Social and Health Services' Research and Data Analysis Division examined medical and chemical dependency treatment records for nearly 129,000 adult Supplemental Security Income (SSI) recipients to determine need for and receipt of chemical dependency treatment services.[1] Some 16% were found to be in need of treatment, and, of these, 50% received chemical dependency treatment between July 1997 and December 2001.

Medical, mental health, and nursing home cost differences between those who received treatment and those who did not were measured. After adjusting for age, race, sex, and prior medical expenses, and also subtracting costs of chemical dependency treatment (including detoxification), average monthly costs were $252 higher per month for individuals who did not receive treatment than for those who received at least some treatment. The differential was even greater for those completing chemical dependency treatment.

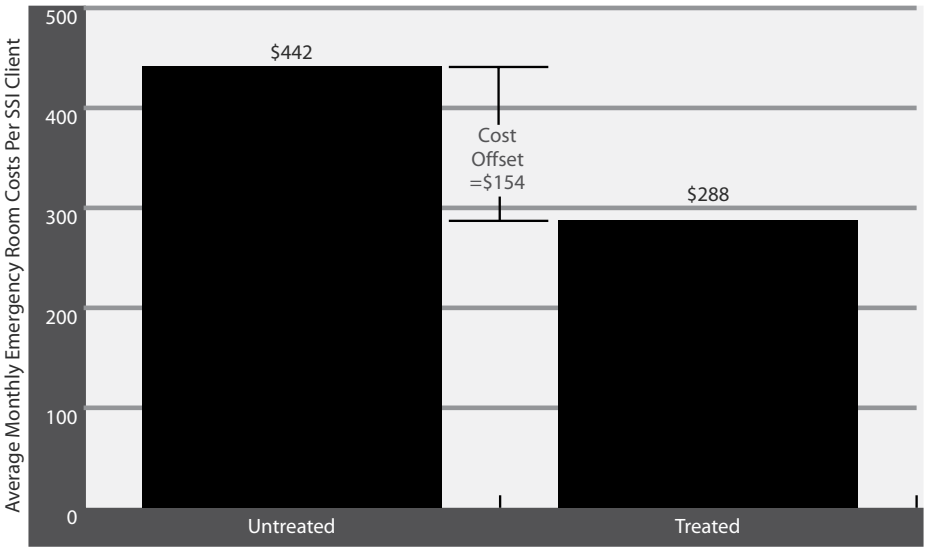
In addition, chemical dependency treatment for SSI recipients was associated with better criminal justice outcomes: for those who completed treatment, a 43% reduced likelihood of arrest; a 38% reduced likelihood of any conviction; and a 48% reduced likelihood of a felony conviction.

As a result of new funds made available with the enactment of the Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005, some 10,915 Medicaid Disabled patients - a significant portion of whom were SSI recipients - received treatment in SFY 2008.

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

[1] Estee, S. & Nordlund, D. *Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report*. Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2003.

# Savings in Emergency Room Costs Associated with Chemical Dependency Treatment Provided to Supplemental Security Income (SSI) Recipients More Than Offset the Cost of Treatment.*

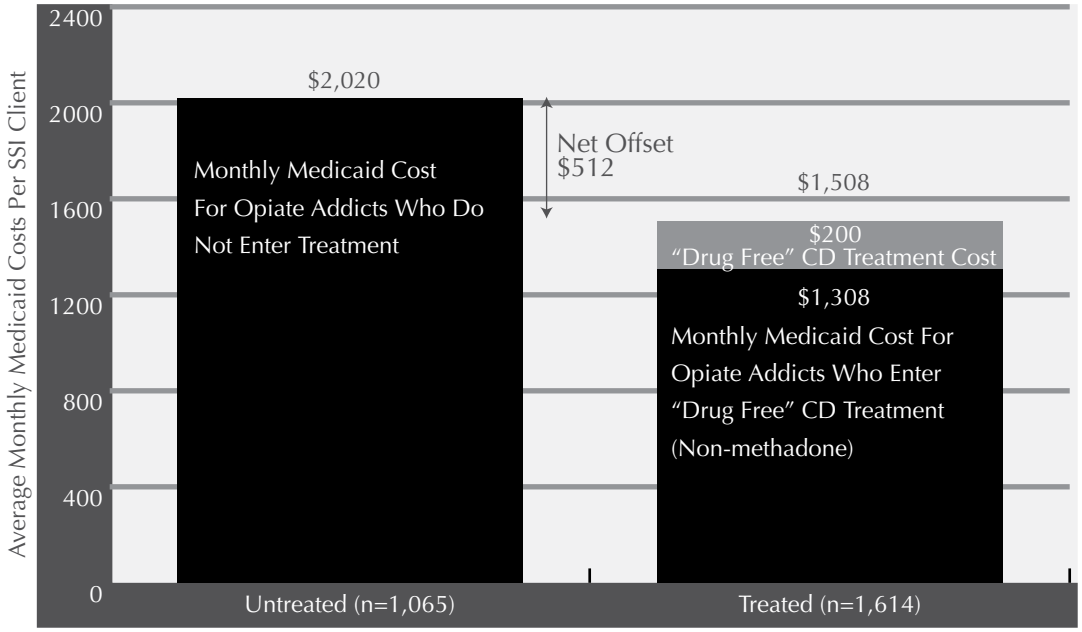



Source: Nordlund, D., et al., "Chemical Dependency Treatment Reduces Emergency Room Costs and Visits: Washington State Supplemental Security Recipients." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

In a study of almost 124,000 Supplement Security Income (SSI) recipients between July 1997 and December 2001, it was found that average monthly emergency room costs for those who were in need of chemical dependency treatment and received it were $154 lower than for those who needed treatment but did not receive it. The number of visits per year was 19% lower, and average cost per visit was 29% lower. The savings in emergency room costs alone almost offset the average monthly cost of chemical dependency treatment ($162).

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot qualify for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

# Providing Drug-Free Chemical Dependency Treatment to Opiate-Addicted Supplemental Security Income (SSI) Recipients Reduces Medical Costs.*



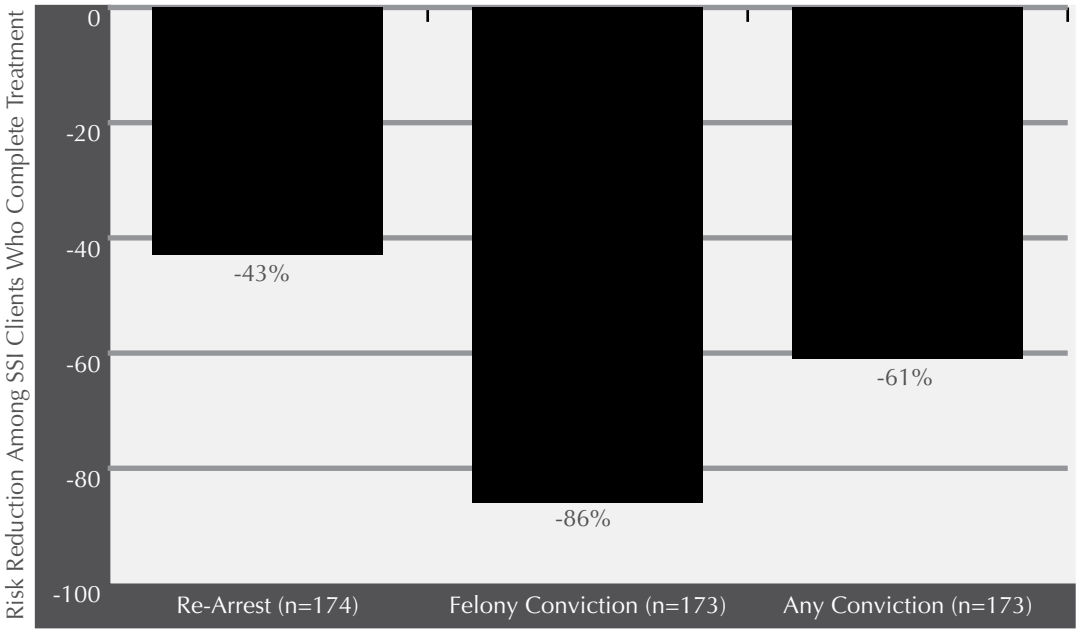

Source: Nordlund, D., et al., "Non-Methadone Chemical Dependency Treatment for Opiate Addiction Reduces Health Care Costs, Arrests and Convictions: Washington State Supplemental Security Recipients." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2004.

Medicaid-paid medical, mental health, and long-term care costs are significantly reduced when opiate-addicted SSI recipients participate in "drug-free" (non-methadone) chemical dependency treatment programs. After costs of treatment are deducted, the average monthly net cost offset is $520. Monthly net cost offsets are higher for those who complete treatment ($629) than for those who do not ($479).[1]

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot quality for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*

[1] Nordlund, D., et al. "Non-Methadone Chemical Dependency Treatment for Opiate Addiction Reduces Health Care Costs, Arrests and Convictions: Washington State Supplemental Security Recipients - Research and Data Analysis Division, 4.50fs." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2004.

# Opiate-Addicted Supplemental Security Income (SSI) Recipients Who Complete Drug-Free Chemical Dependency Treatment Have Dramatically Reduced Risks of Re-Arrest, Felony Conviction, and Any Conviction.*




Source: Nordlund, D., et al., "Non-Methadone Chemical Dependency Treatment for Opiate Addiction Reduces Health Care Costs, Arrests and Convictions: Washington State Supplemental Security Recipients." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2004.

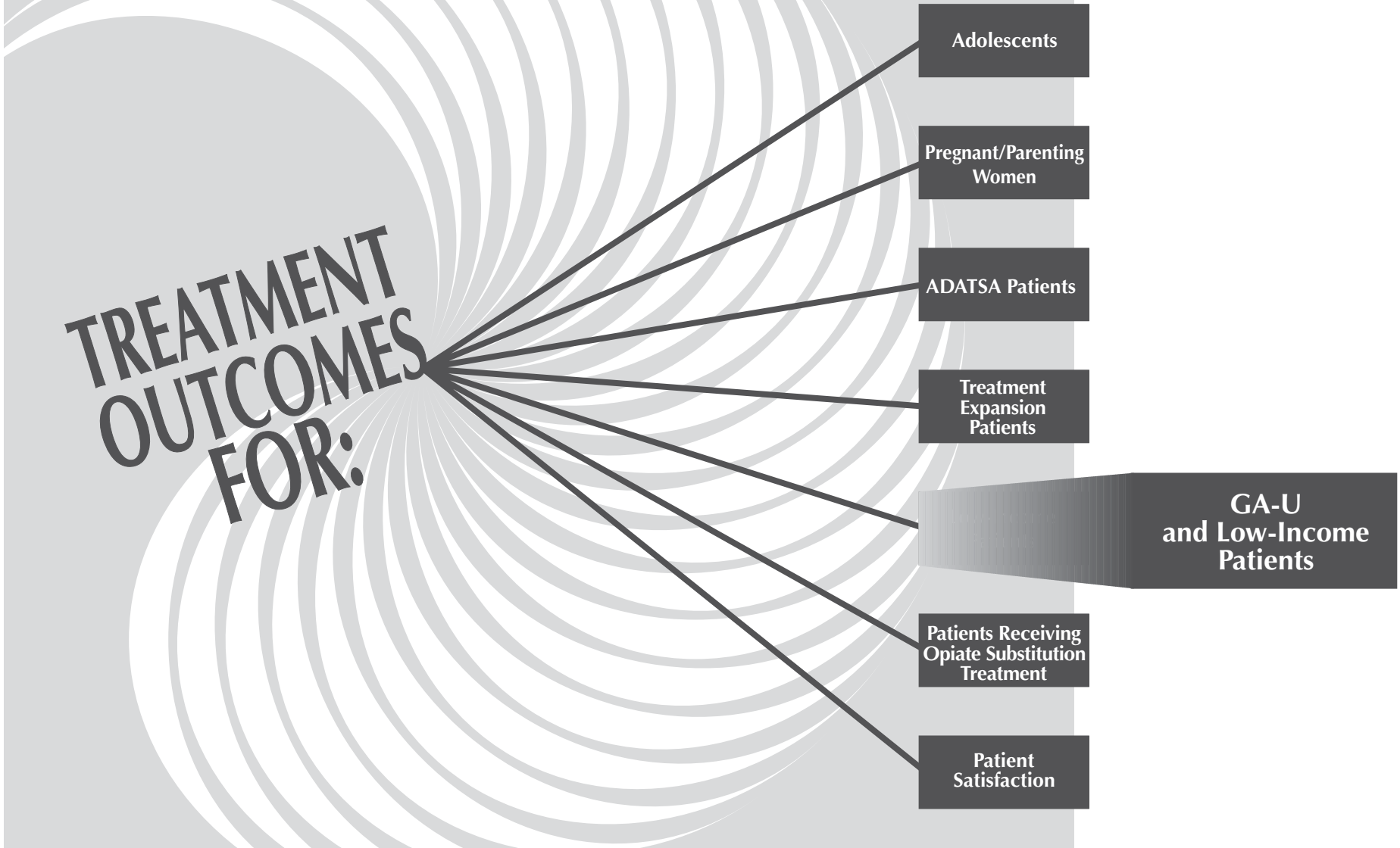
Completion of "drug-free" (non-methadone) chemical dependency treatment by opiate-addicted SSI results in substantially lower risks of criminal recidivism, felony conviction, and any conviction. It also results in dramatically lower Medicaid-paid medical costs.[1]

**Under the Supplemental Security Income (SSI) program, the federal government provides public assistance grants to aged, blind, and disabled persons with limited means and who do not qualify for benefits under Social Security. One cannot quality for SSI benefits as a result of a disabling condition of alcoholism or drug addiction. People eligible for SSI are automatically eligible for Medicaid.*



[1] Nordlund, D., et al. "Non-Methadone Chemical Dependency Treatment for Opiate Addiction Reduces Health Care Costs, Arrests and Convictions: Washington State Supplemental Security Recipients - Research and Data Analysis Division, 4.50fs." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, June 2004.

# Outcomes: The Benefits of Prevention & Treatment



# Profile of General Assistance-Unemployable Clients Receiving Publicly Funded Chemical Dependency Treatment in Washington State

A profile of adults receiving General Assistance-Unemployable (GA-U) admitted to publicly funded chemical dependency in Washington State in SFY 2008 reveals the following characteristics at time of admission:[1]

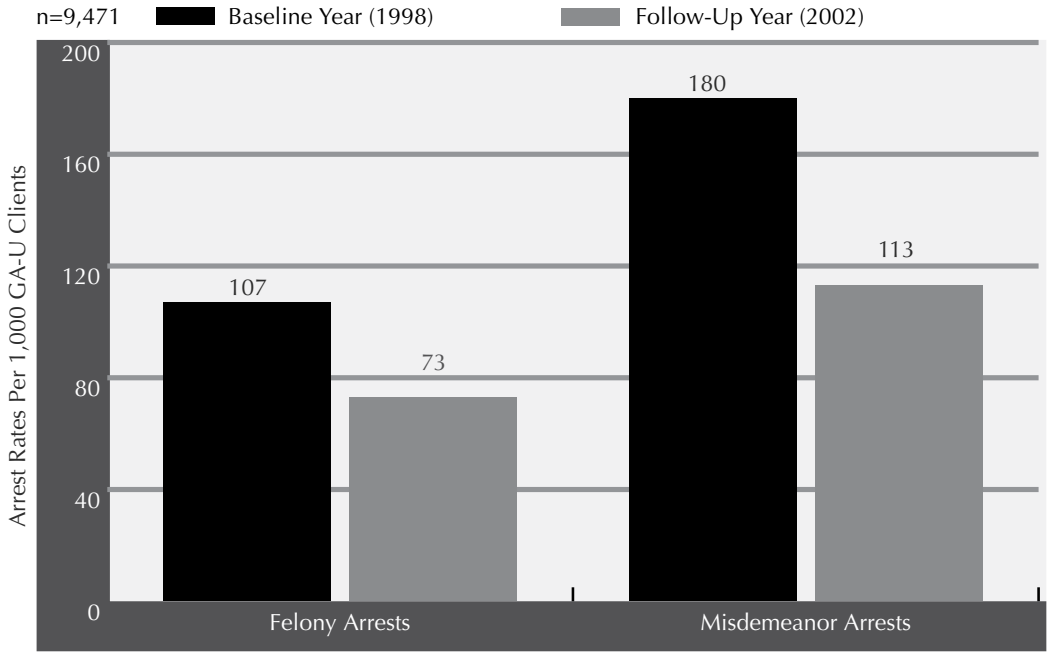
| | |
|---|---|
| *Number of Individuals Admitted:* | 2,098 |
| *Median Age:* | 41 |
| *Gender:* | 64% Male; 36% Female |
| *Employment Status:* | Employed (full- or part-time) – 4%; Unemployed – 96% |
| *Primary Drug:* | Alcohol – 43%; Methamphetamine - 15%; Cocaine – 12%; Heroin – 11% |
| *% with Previous Admission:* | 55% |
| *Criminal Justice Involvement:* | 56% arrested at least once in previous year |
| *% with Children in the Home:* | 6% |
| *% with Co-Occurring Disorder:* | 46% with co-occurring mental health disorder |
| *Housing Status:* | 25% homeless* |

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

Individuals may qualify for GA-U benefits if they are incapacitated and unable to perform basic work-related activities, and are not eligible for Temporary Assistance for Needy Families (TANF) or Supplement Security Income (SSI). They may be referred for chemical dependency assessments and treatment if it is believed that doing so will improve the possibility of their becoming gainfully employed.

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, November 2009. Data include unduplicated admissions to treatment. Detoxification, transitional house, and private-pay and Department of Corrections patients are excluded.

# Rates of Arrest for Individuals Receiving General Assistance-Unemployable (GA-U) Decline Substantially Even Four Years Following Chemical Dependency Treatment.



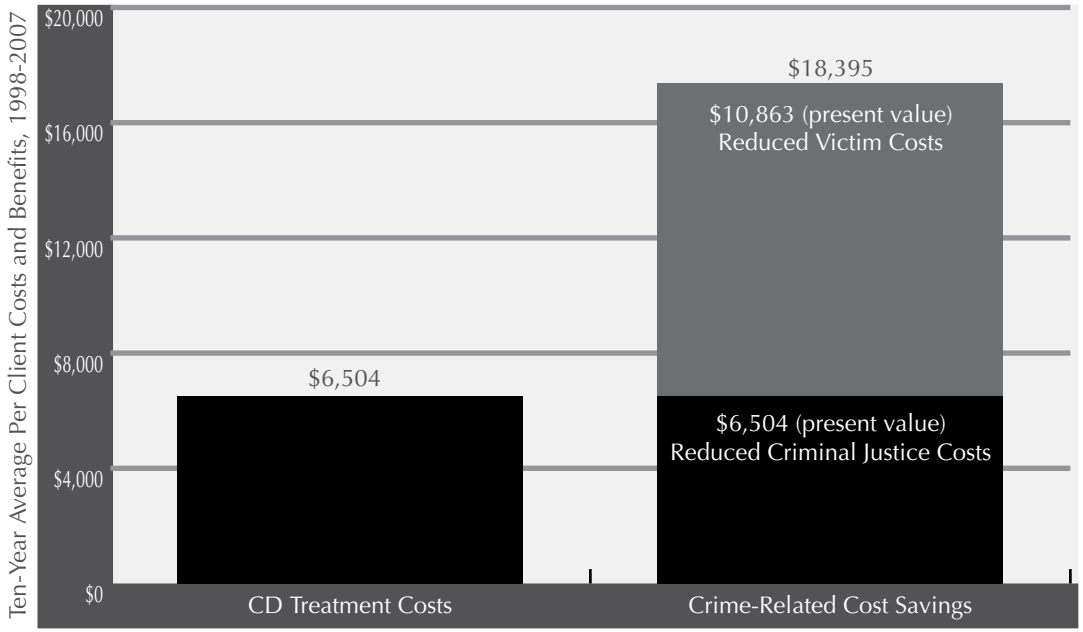

Source: Wickizer, T., et al.,"Substance Abuse Treatment of Welfare Clients in Washington State, Part I: Need for Treatment and Criminal Activity Outcomes." Manuscript in press, 2007.

The General Assistance-Unemployable (GA-U) program is a state-paid welfare program for individuals who are unemployable due to a physical or mental disability lasting at least 90 days. A recent study found that 12.3% of GA-U clients are in need of substance abuse treatment.[1] The study found that among GA-U clients who received chemical dependency treatment in 1998, felony arrests four years later were 31.8% lower, and misdemeanor rates 37.2% lower than in the year treatment was received.



[1] Wickizer, T., et al. "Substance Abuse Treatment of Welfare Clients in Washington State, Part I: Need for Treatment and Criminal Activity Outcomes." Manuscript in press, 2007.

# Providing Chemical Dependency Treatment to GA-U Clients Results in Significantly Reduced Costs to Crime Victims and the Criminal Justice System.

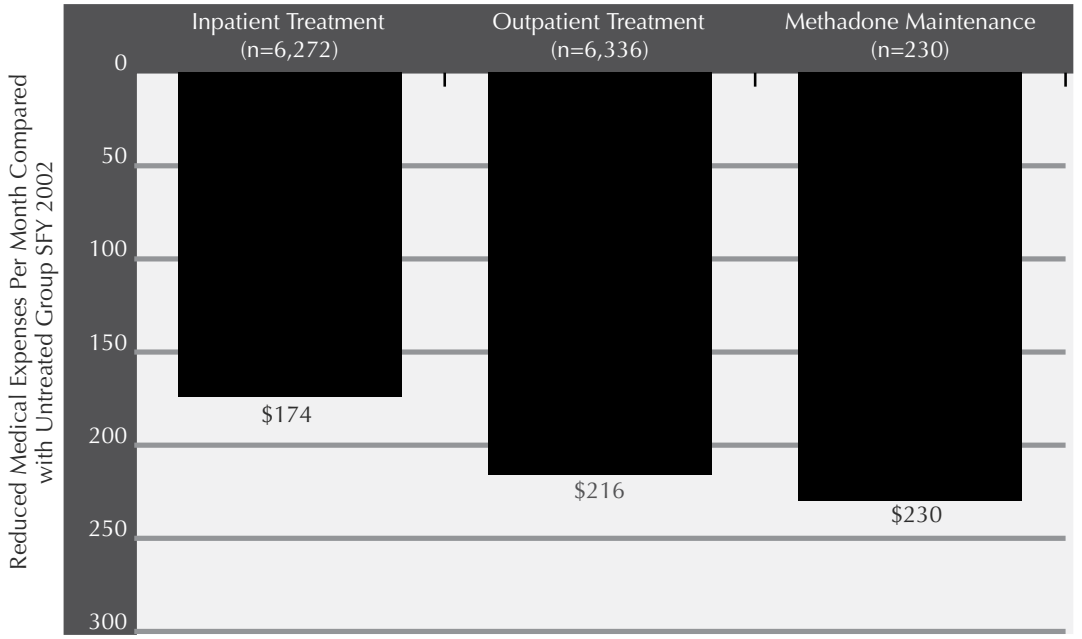



Source: Mancuso, D., and Felver, B., *Chemical Dependency Treatment, Public Safety Implications for Arrest Rates, Victims and Community Protection – Report 11.140.* Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2009.

In 2006, individuals on General Assistance-Unemployable (GA-U) who received chemical dependency treatment experienced a 33% decline in the number of arrests per client in the following year compared with GA-U clients who needed but did not receive treatment. Although clients may engage in treatment over a number of years, the 10-year crime-related cost savings, even accounting for the cost of treatment, were $11,889. The present total value of crime-related cost savings were $70 million in 2006. This is in addition to costs savings resulting from reduced medical care and hospitalization, higher rates of employment, and worker productivity.[1]

[1] Mancuso, D., and Felver, B. *Chemical Dependency Treatment, Public Safety Implications for Arrest Rates, Victims and Community Protection – Report 11.140.* Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2009.

# Medical Care Expenses are Significantly Lower for Individuals Receiving General Assistance-Unemployable (GA-U) Three Years Following Chemical Dependency Treatment.




Source: Wickizer, T., et al.,"The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State." *Milbank Quarterly* 84, 2006.

The General Assistance-Unemployable (GA-U) program is a state-paid welfare program for individuals who are unemployable due to a physical or mental disability lasting at least 90 days. A recent study found that among GA-U clients who received chemical dependency treatment in SFY 1999, medical expenses in SFY 2002 were substantially lower than for those who were in need of treatment but did not receive it. Savings were $2,087/year for those receiving inpatient treatment, $2,587 for outpatient, and $2,763 for those receiving methadone maintenance.[1]



[1] Wickizer, T., et al. "The Effect of Substance Abuse Treatment on Medicaid Expenditures among General Assistance Welfare Clients in Washington State." *Milbank Quarterly* 84, 2006.

# Profile of Low-Income Adults Receiving Publicly Funded Chemical Dependency Treatment in Washington State

A profile of low-income adults admitted to publicly funded chemical dependency treatment in Washington State in SFY 2008 reveals the following characteristics at time of admission:[1]

| | |
|---|---|
| *Number of Individuals Admitted:* | 9,316 |
| *Median Age:* | 33 |
| *Gender:* | 75% Male; 25% Female |
| *Employment Status:* | Employed (full- or part-time) – 46%; Unemployed – 54% |
| *Primary Drug:* | Alcohol – 55%; Marijuana - 15% ; Methamphetamine - 13% |
| *% with Previous Admission:* | 35% |
| *Criminal Justice Involvement:* | 73% arrested at least once in previous year |
| *% with Children in the Home:* | 29% |
| *% with Co-Occurring Disorders:* | 15% with a co-occurring mental health disorder |
| *Housing Status:* | 6% homeless* |

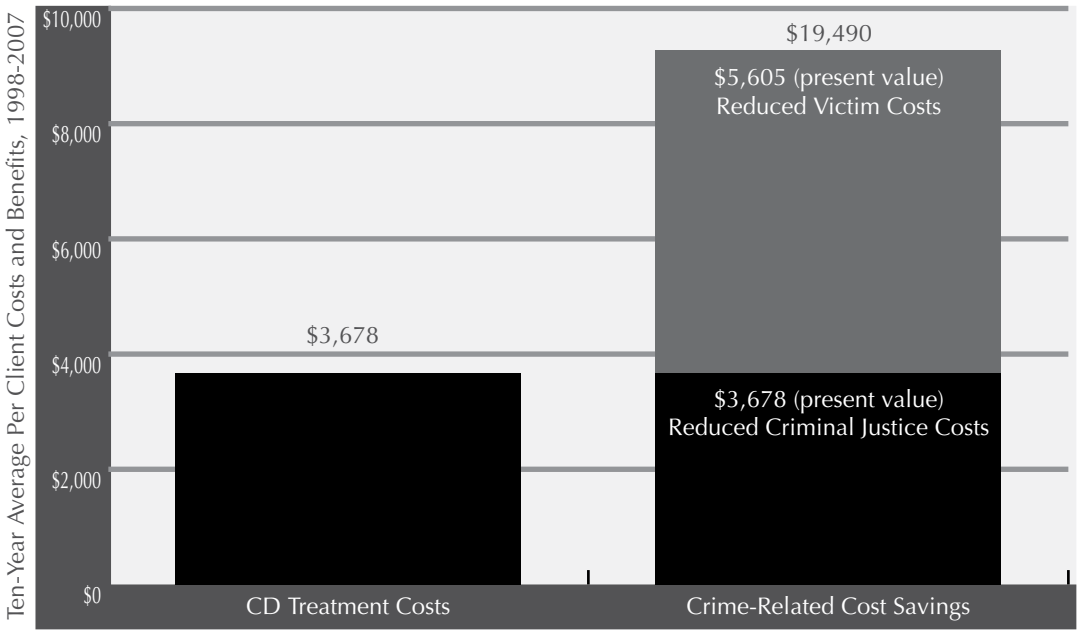
**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

Low-Income patients are those who receive publicly funded chemical dependency treatment but do not receive Medicaid and are not covered by another state-funded payment source. Compared with other publicly funded patients, they are more like to be employed, more likely to have been arrested in the previous year, less likely to be homeless, and less likely to have a co-occurring mental health disorder. In 2006, the estimated present value of crime-related savings resulting from the treatment of low-income patients was $104 million.[2]

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, November 2009. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.
[2] Mancuso, D., and Felver, B. *Chemical Dependency Treatment, Public Safety Implications for Arrest Rates, Victims and Community Protection – Report 11.140.* Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2009.

NEW/CHANGING TREND

# Providing Chemical Dependency Treatment to Low-Income Clients Results in Significantly Reduced Costs to Crime Victims and the Criminal Justice System.




Source: Mancuso, D., and Felver, B., *Chemical Dependency Treatment, Public Safety Implications for Arrest Rates, Victims and Community Protection – Report 11.140.* Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2009.

In 2006, low-income adults (those without DSHS medical coverage or who were not covered through another state payment source) who received chemical dependency experienced an 17% decline in the number of arrests per client in the following year compared with Alcoholism and Drug Addiction and Support Act (ADATSA) clients who needed but did not receive treatment. Although clients may engage in treatment over a number of years, the 10-year crime-related cost savings, even accounting for the cost of treatment, were $5,812. The present total value of crime-related cost savings were $104 million in 2006. This is in addition to costs savings resulted from reduced medical care and hospitalization, higher rates of employment, and worker productivity.[1]



[1] Mancuso, D., and Felver, B. *Chemical Dependency Treatment, Public Safety Implications for Arrest Rates, Victims and Community Protection – Report 11.140.* Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, February 2009.

# Profile of Adults Receiving Temporary Assistance for Needy Families Served By Publicly Funded Chemical Dependency Treatment Programs in Washington State

A profile of patients receiving Temporary Assistance for Needy Families (TANF) admitted to publicly funded treatment in Washington State in SFY 2008 reveals the following characteristics at time of admission:[1]

| | |
|---|---|
| *Number of Individuals Admitted:* | 4,151 |
| *Median Age:* | 29 |
| *Gender:* | 24% Male; 76% Female |
| *Employment Status:* | Employed (full- or part-time) – 16%; Unemployed – 84% |
| *Primary Drug:* | Alcohol – 33%; Methamphetamine - 24%;<br>Marijuana – 17%; Prescription-type Opiates – 10% |
| *% with Previous Admission:* | 49% |
| *Criminal Justice Involvement:* | 54% arrested at least once in previous year |
| *% with Children in the Home:* | 77% |
| *Housing Status:* | 7% homeless* |

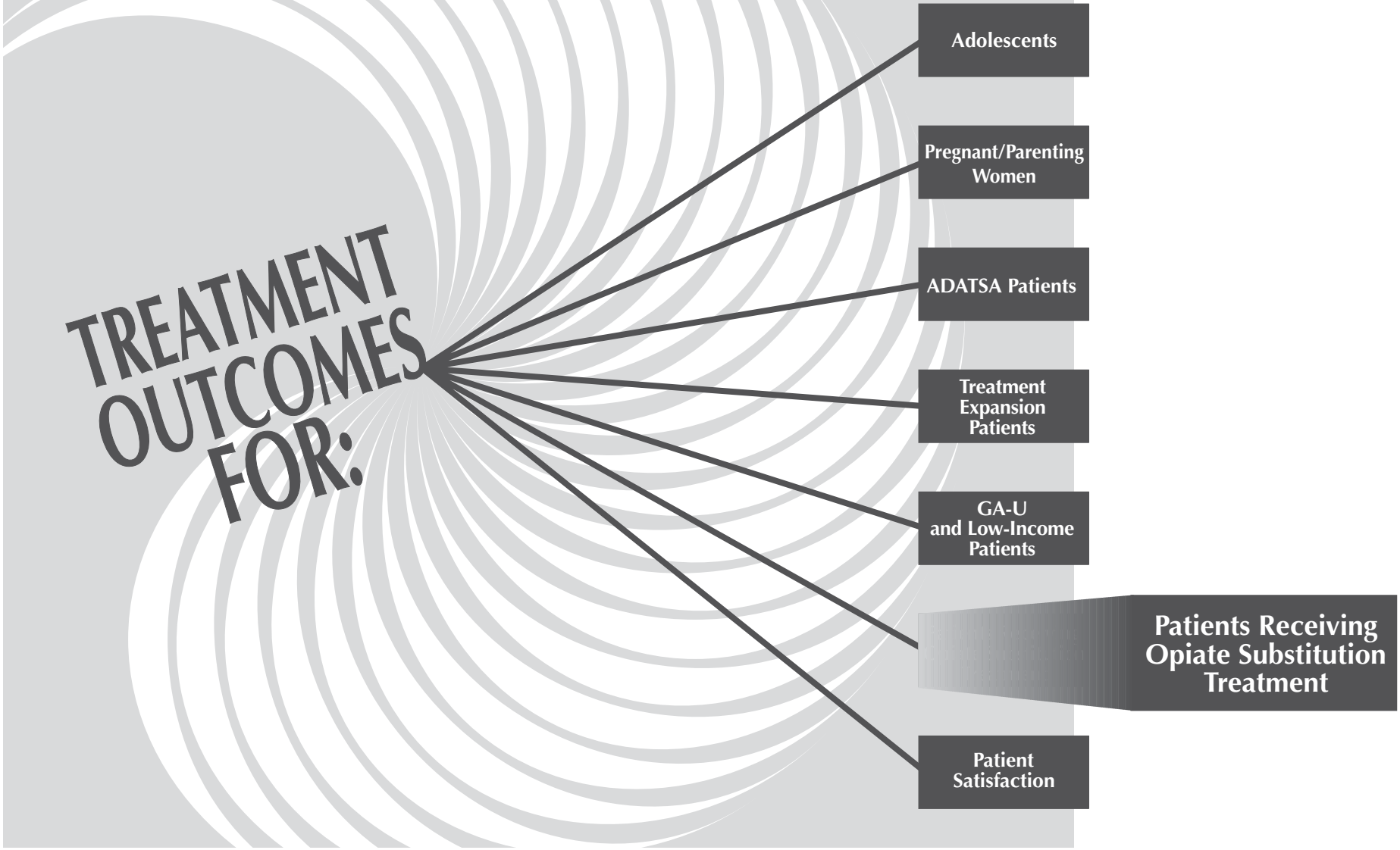
Of women receiving TANF admitted to publicly funded treatment in Washington State during SFY 2008:

- More than one-third (37%) did not have a high school diploma or GED.
- More than half (53%) reported they had been victims of domestic violence at some point in their lives.
- Almost a quarter (22%) reported receiving mental health treatment in the past year.
- 11% reported using injection as a route of drug administration.[2]

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, November 2009. Data include unduplicated admissions to treatment. Detoxification, transitional housing, and private-pay and Department of Corrections patients are excluded.
[2] TARGET, November 2009.

# Outcomes: The Benefits of Prevention & Treatment



# Profile of Patients Receiving Publicly Funded Opiate Substitution Treatment in Washington State

Opiate substitution treatment has been scientifically shown to work. The federal Office of National Drug Control Policy called methadone therapy, "one of the longest-established, most thoroughly evaluated forms of drug treatment."[1] A Consensus Panel convened by the National Institutes of Health concluded, "Methadone treatment significantly lowers illicit opiate drug use, reduces illness and death from drug use, reduces crime, and enhances social productivity."[2]

In SFY 2008, 7,600 received opiate substitution treatment in Washington State, of whom 4,747 (representing 62.5%) were publicly funded, and 2,853 (representing 37.5%) were private-pay. Of those publicly funded and served in SFY 2008, 76.6% remained in treatment at least one year.[3]

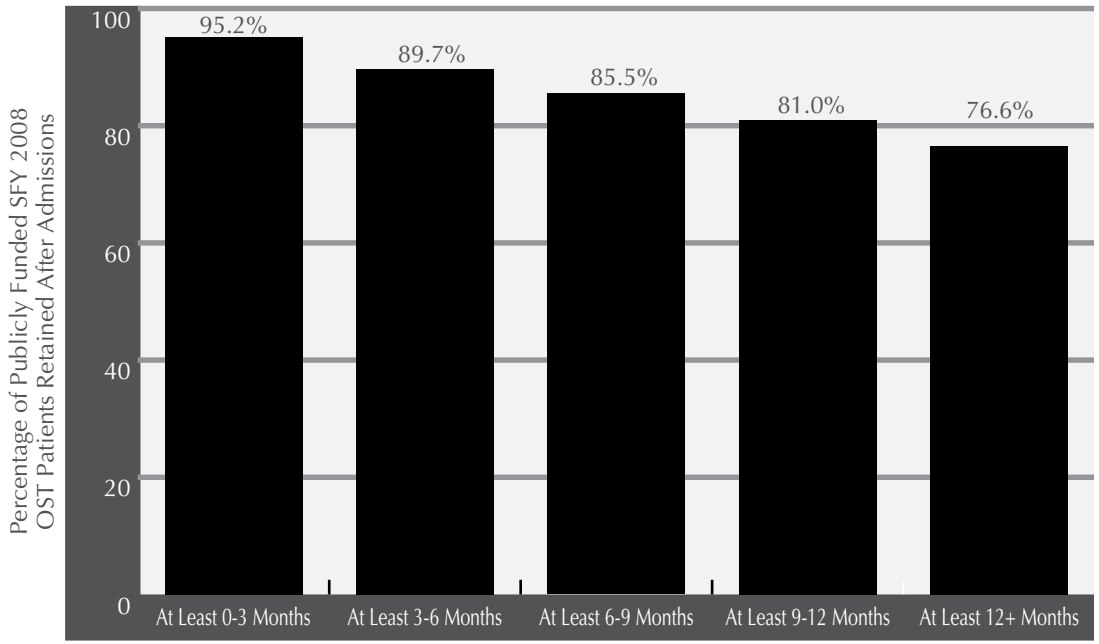
| | |
|---|---|
| *Number of Individuals Admitted:* | 1,573 |
| *Median Age:* | 37 |
| *Gender:* | 49% Male; 51% Female |
| *Employment Status:* | Employed (full- or part-time or temporary) – 12%; Unemployed – 88% |
| *Primary Drug:* | Heroin – 65%; Prescription-Type Opiates– 35% |
| *% with Previous Admission:* | 57% |
| *Criminal Justice Involvement:* | 42% arrested at least once in previous year |
| *% with Children in the Home:* | 27% |
| *% with Co-Occurring Disorder:* | 39% with a co-occurring mental health disorder |
| *Housing Status:* | 19% homeless* |

**Includes homeless shelter/mission, on the street, transient quarters, no stable arrangement categories.*

[1] Office of National Drug Control Policy. *The National Drug Control Strategy: 2000 Annual Report*. Washington, DC: Office of the White House, 2000.
[2] National Institutes of Health. *Effective Medical Treatment of Heroin Addiction: NIH Consensus Statement 1997*. November 17-19, 1997 15(6).
[3] Treatment and Assessment Report Generation Tool (TARGET). Olympia, WA: Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery, November 2009.

NEW/CHANGING TREND

# More than Three-Quarters of Patients Receiving Publicly Funded Opiate Substitution Treatment (OST) in SFY 2008 were Retained for at Least One Year.




Source: Treatment and Assessment Report Generation Tool (TARGET), Division of Behavioral Health and Recovery, Washington State Department of Social and Health Services, 2009.

Longer duration of opiate substitution treatment is associated with better patient outcomes, including reduced drug use and increased abstinence, reduced illegal activity, and fewer hospital admissions.[1] In recent years, a significantly higher proportion of patients admitted to opiate substitution treatment report prescription-type opiates as their primary substance of abuse. A study published in 2009 found that there was no statistically significant difference in treatment retention by opiate type (i.e. heroin v. prescription-type opiates) after adjusting for demographics, treatment agencies, other drug use, public assistance type, medical, psychiatric, social, legal and familial factors.[2]

[1] Jackson, T. "Treatment Practice and Research Issues in Improving Opioid Treatment Outcomes." *Science and Practice Perspectives* 1(1), July 2002; Carney, M. *Drug Use, Jail Time, and Illegal Activities Among Clients Admitted to Methadone Maintenance at Admissions and 6 Months Later.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2001; Luchansky, B., et al. "Inpatient Hospital Admissions for Clients in Opiate Substitution Treatment: Longitudinal Analyses from Washington State". *Substance Use and Misuse 32,* 2007.
[2] Banta-Green, C., et al. "Retention in Methadone Maintenance Drug Treatment for Prescription-Type Opioid Primary Users Compared to Heroin Users." *Addiction* 104(5), 2009.

# Patients Receiving Opiate Substitution Treatment Have a Significantly Reduced Risk of Arrest.

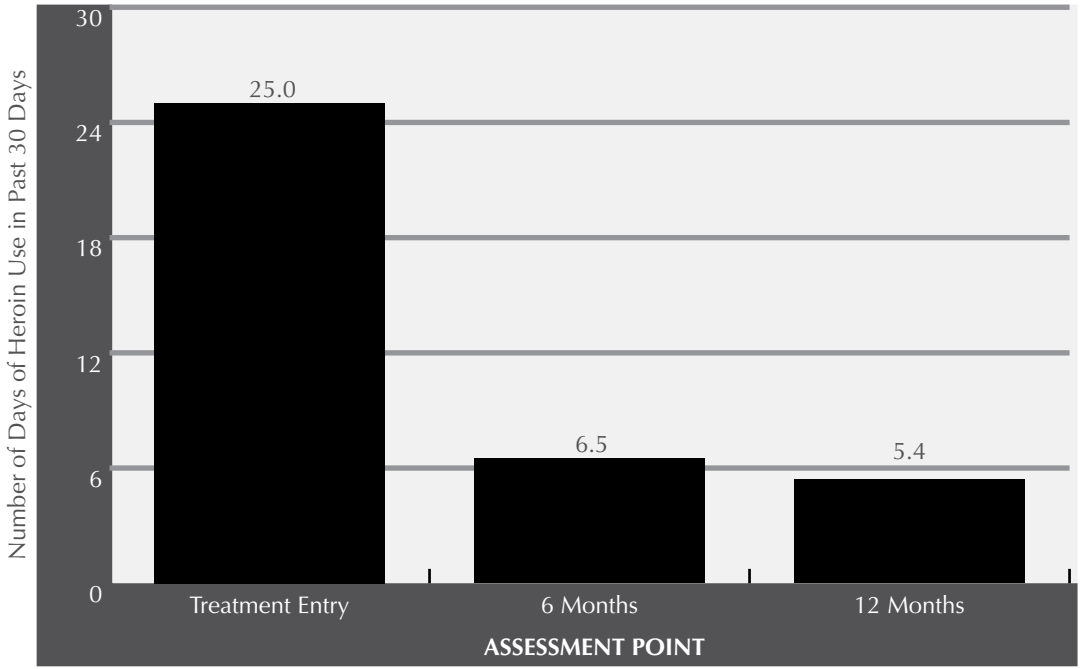
A DASA-funded three-year prospective study of the impact of substance abuse treatment on arrests among 12,962 opiate users in Washington State indicated a significantly reduced risk of arrest among patients receiving opiate substitution treatment.[1] This was especially true among those who remained in treatment for more than 90 days.

The study found:

- Those receiving opiate substitution treatment for more than 90 days had a 42% lower risk of arrest while in treatment than those who never received treatment. The risk for those in treatment less than 90 days was 22% lower.
- For those without a recent (past-year) history of felony or gross misdemeanor arrest, those receiving opiate substitution treatment for more than 90 days had a 48% lower risk of arrest while in treatment than those who never received treatment. The risk for those in treatment less than 90 days was 36% lower.
- For those with a recent (past-year) history of felony or gross misdemeanor arrest, those receiving opiate substitution treatment for more than 90 days had a 25% lower risk of arrest while in treatment than those who never received treatment. The difference in risk for those in treatment less than 90 days was not statistically significant.

[1] Campbell, K., Deck, D., and Krupski, A. "Impact of Substance Abuse Treatment on Arrests Among Opiate Users in Washington State," *The American Journal on Addictions* 16(6), 2007.

# Patients Receiving Opiate Substitution Treatment Show Significant Decreases in Heroin Use.



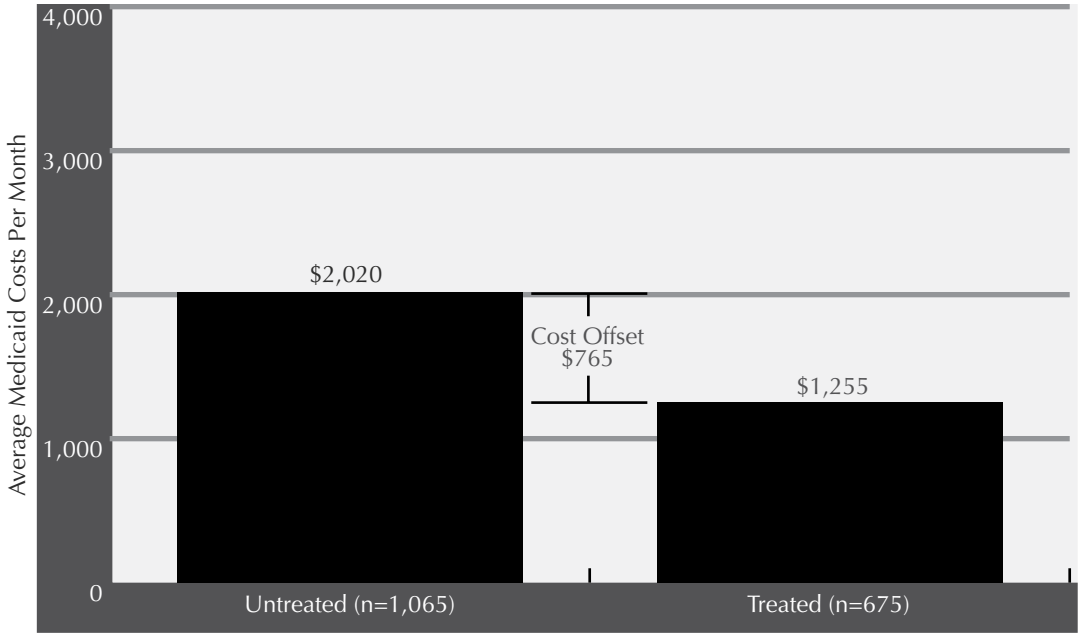

Source: Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

A 2003 study of 135 patients admitted to publicly funded opiate substitution treatment in Washington State in 2000 demonstrated significant reductions in the average number of days they engaged in heroin use. At entry into treatment, patients reported an average of 25 days of heroin use in the past 30 days. At six months, this was reduced to 6.5 days, and at 12 months, to 5.4 days, representing a 78% decline. More than four out of five patients reported a reduction in the number of days using heroin at the six- and 12-month follow-ups.[1]



[1] Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

# Providing Methadone Treatment for Opiate-Addicted Supplemental Security Income Recipients Reduces Health Care Costs.



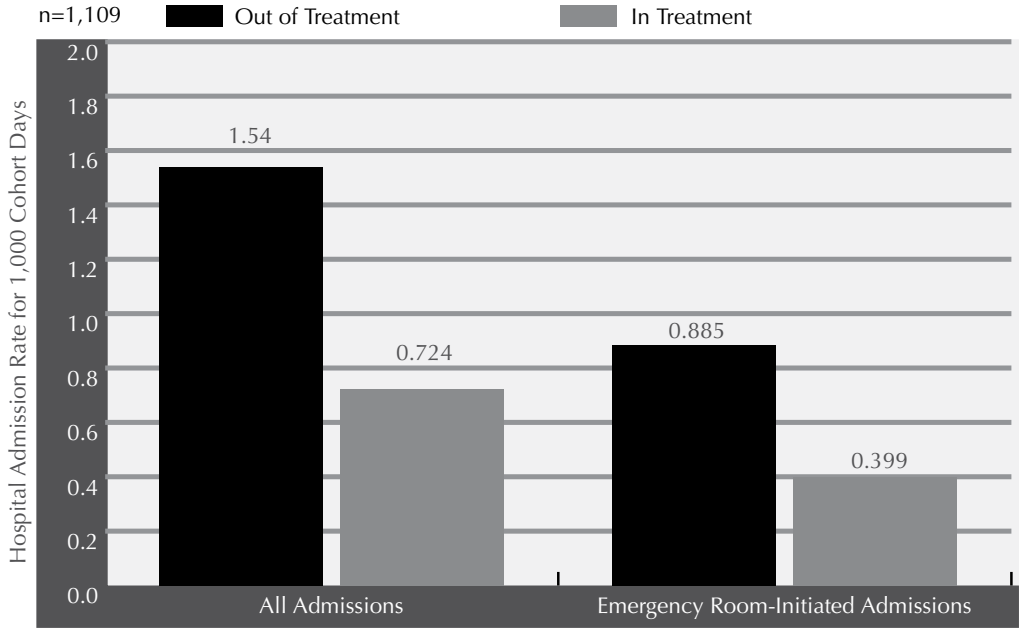

Source: Nordlund, D., et al., "Methadone Treatment for Opiate Addiction Lowers Health Care Costs and Reduces Arrests and Convictions." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis Division, May 2004.

Medicaid-paid medical, mental health, and long-term care costs are significantly lower for Supplemental Security Income (SSI) recipients addicted to opiates who receive methadone treatment, compared to those who remain untreated. Even after the monthly cost of treatment ($219/month) is included, the net cost savings per patient is $765 per month, or a potential savings of $9,180 per treated SSI recipient per year.

Savings are substantial ($725/month) even for SSI recipients who are opiate-addicted even if they leave treatment within the first 90 days. However, for those who remain in treatment for at least one year, cost offsets rise to $899 per month per recipient.

[1] Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

# Patients Receiving Opiate Substitution Treatment Have Significantly Lower Hospital Admission Rates While in Treatment.



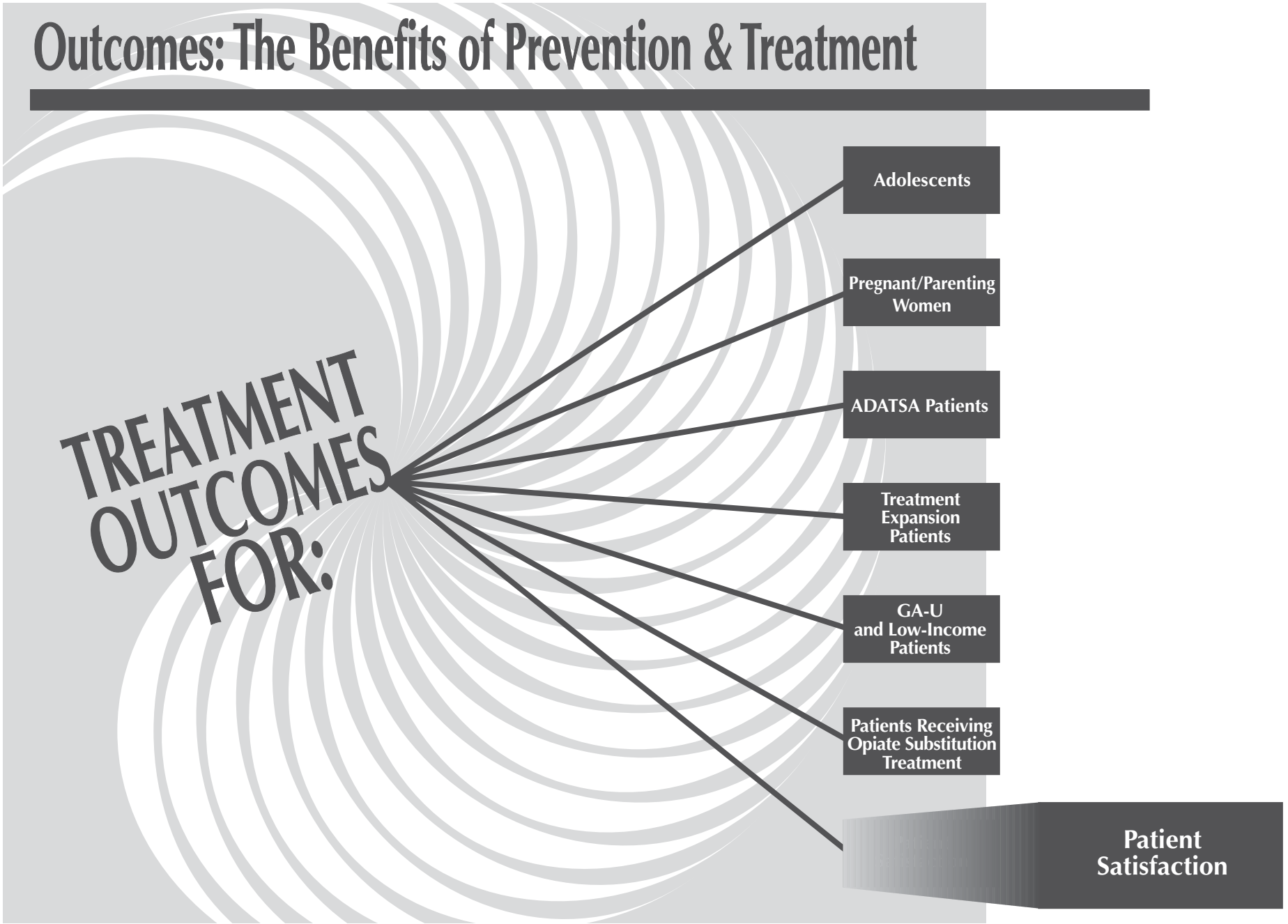

Source: Luchansky, B., et al., "Inpatient Hospital Admissions for Clients in Opiate Substitution Treatment: Longitudinal Analyses from Washington State," *Substance Use and Misuse* 32, 2007.

A study of 1,109 opiate-addicted patients in and out of opiate substitution treatment found patients in treatment had 52.9% fewer hospital admissions while in treatment than when out of treatment. These same patients had 54.9% fewer emergency room-initiated (ER) admissions. Some 56% of hospital admissions were through the ER, and 21% through an urgent care facility. Medicaid or Medicare paid for 82% of these admissions. Reduced medical service utilization and hence reductions in health care costs are among the major outcomes of opiate substitution treatment.[1]



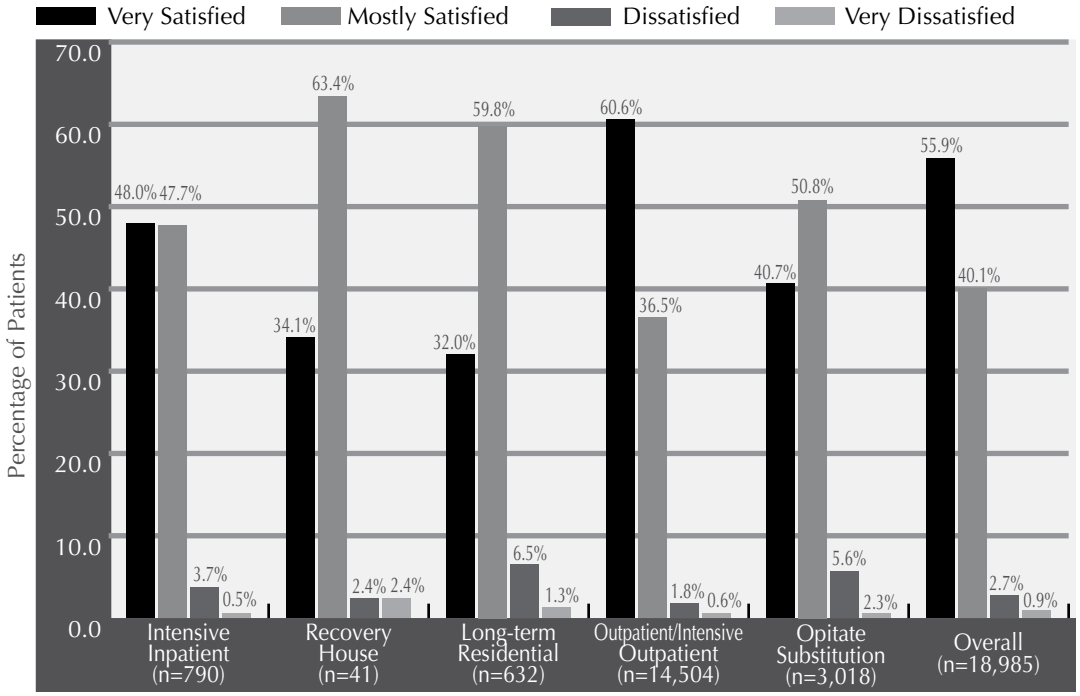
[1] Luchansky, B., et al. "Inpatient Hospital Admissions for Clients in Opiate Substitution Treatment: Longitudinal Analyses from Washington State." *Substance Use and Misuse* 32, 2007.

# Outcomes: The Benefits of Prevention & Treatment



# In 2009, 96% of Adult Patients Receiving Chemical Dependency Treatment in Community-Based Programs Reported Overall Satisfaction with the Service They Received.

***"In an overall, general sense, how satisfied are you with the service you have received?"***



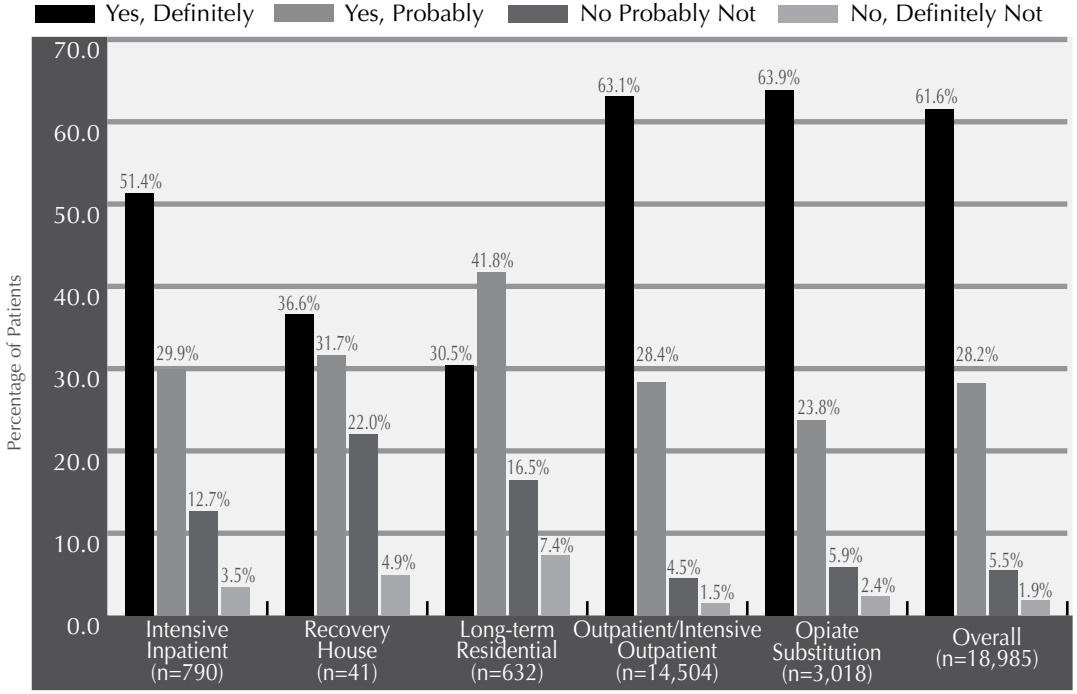

Source: Rodriguez, F., *Patients Speak Out 2009: Eighth Statewide Patient Satisfaction Survey.* Olympia, WA: Division of Alcohol and Substance Abuse, 2009.

In March 2009, DASA conducted its eighth statewide patient satisfaction survey. It was administered at 490 community-based and correctional treatment centers to 22,2224 patients, or 72% of those receiving treatment in the participating agencies during the week of the survey.

Overall, 95% of adult patients treated in community-based agencies reported they were satisfied with the comfort and appearance of their treatment facilities; 81% said they were always treated with respect by staff; 91% rated group sessions as helpful, and 89% reported they found individual counseling to be helpful. Reports of responses to the survey are sent to each of the respective treatment agencies for use in quality improvement activities.

# In 2009, 90% of Adult Patients Receiving Chemical Dependency Treatment in Community-Based Programs Reported They Would Return to the Same Program If They Needed Help Again.

***"If you were to seek help again, would you come back to this program?"***



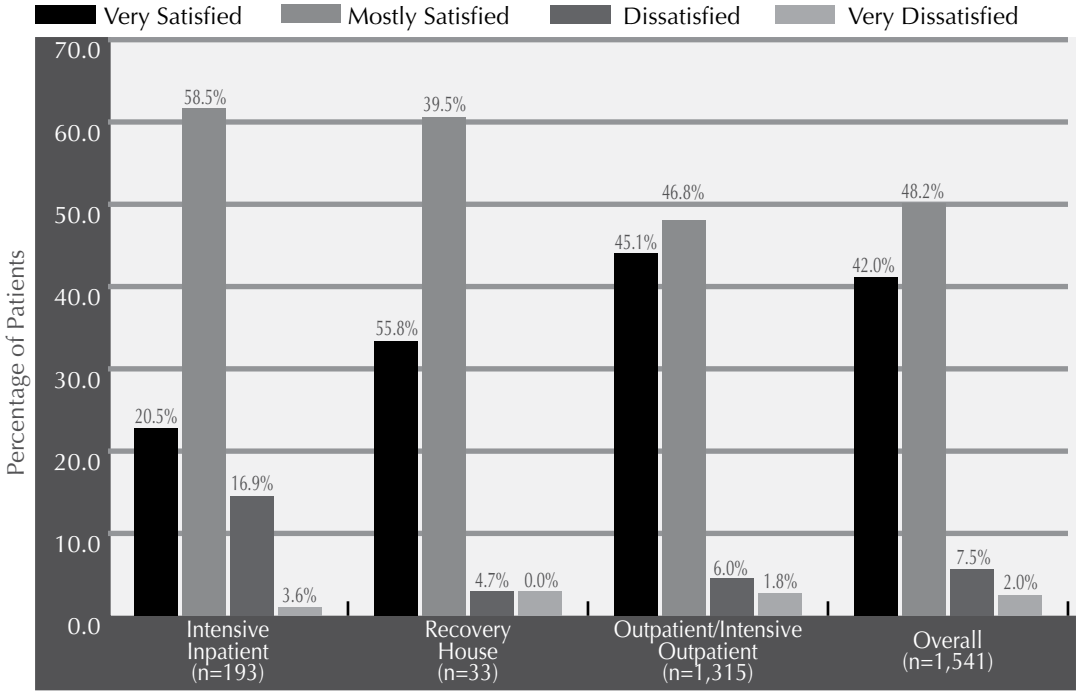

Source: Rodriguez, F., *Patients Speak Out 2009: Eighth Statewide Patient Satisfaction Survey.* Olympia, WA: Division of Alcohol and Substance Abuse, 2009.

In March 2009, DASA conducted its eighth statewide patient satisfaction survey. It was administered at 490 community-based and correctional treatment centers to 22,224 patients, or 72% of those receiving treatment in the participating agencies during the week of the survey.

Many patients receiving chemical dependency treatment require other services as well. Treatment agencies play a key role in assisting patients in identifying and accessing these services. Of those reporting a need for them: 77% of adult patients said their treatment program was helpful in connecting them to legal services: 79% to medical services; 74% to family services; 75% to mental health services; 65% to educational or vocational services; and 55% to employment services.

# In 2009, 91% of Youth Patients Receiving Chemical Dependency Treatment in Community-Based Programs Reported Overall Satisfaction with the Service They Received.

***"How satisfied are you with the service you have received?"***



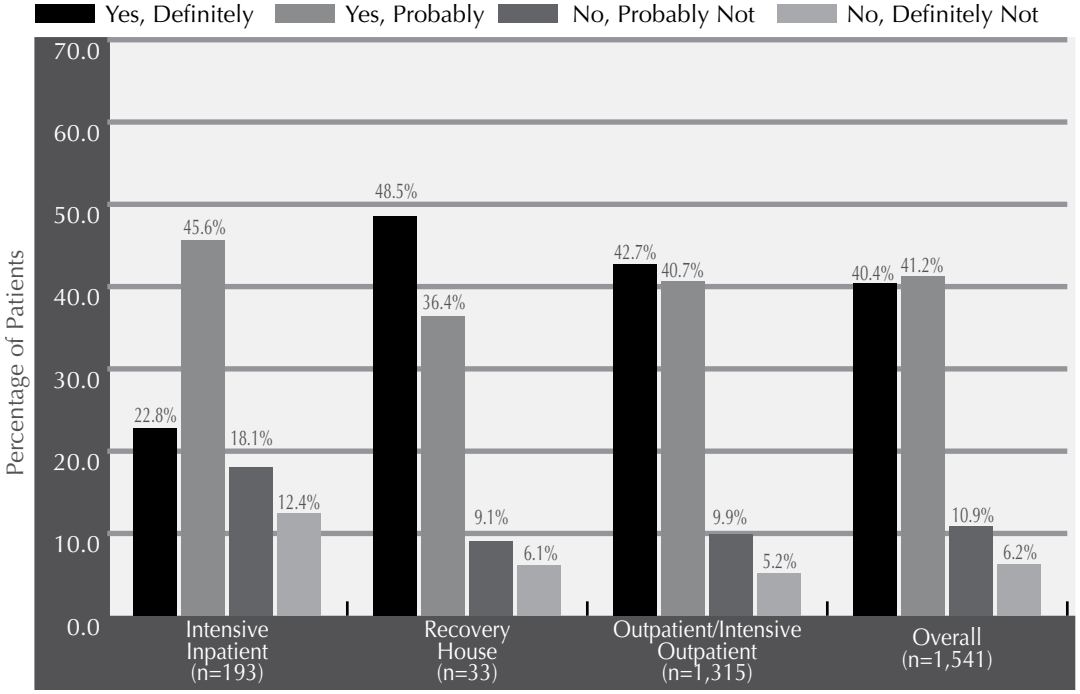

Source: Rodriguez, F., *Patients Speak Out 2009: Eighth Statewide Patient Satisfaction Survey.* Olympia, WA: Division of Alcohol and Substance Abuse, 2009.

In March 2009, DASA conducted its eighth statewide patient satisfaction survey. It was administered at 490 community-based and correctional treatment centers to 22,224 patients, or 72% of those receiving treatment in the participating agencies during the week of the survey.

Overall, 93% of youth patients treated in community-based agencies reported they were satisfied with the comfort and appearance of their treatment facilities; 75% said they were always treated with respect by staff; 84% rated group sessions as helpful, and 82% reported they found individual counseling to be helpful. Reports of responses to the survey are sent to each of the respective treatment agencies for use in quality improvement activities.

# In 2009, 82% of Youth Patients Receiving Chemical Dependency Treatment in Community-Based Programs Reported They Would Return to the Same Program If They Needed Help Again.

***"If you were to seek help again, would you come back to the same program?"***

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This is the seventh year the patient satisfaction survey was conducted among youth. Reports of responses to the survey are sent to each of the respective treatment agencies for use in quality improvement activities.

# Treatment Completion

# Treatment Completion Improves Patient Outcomes

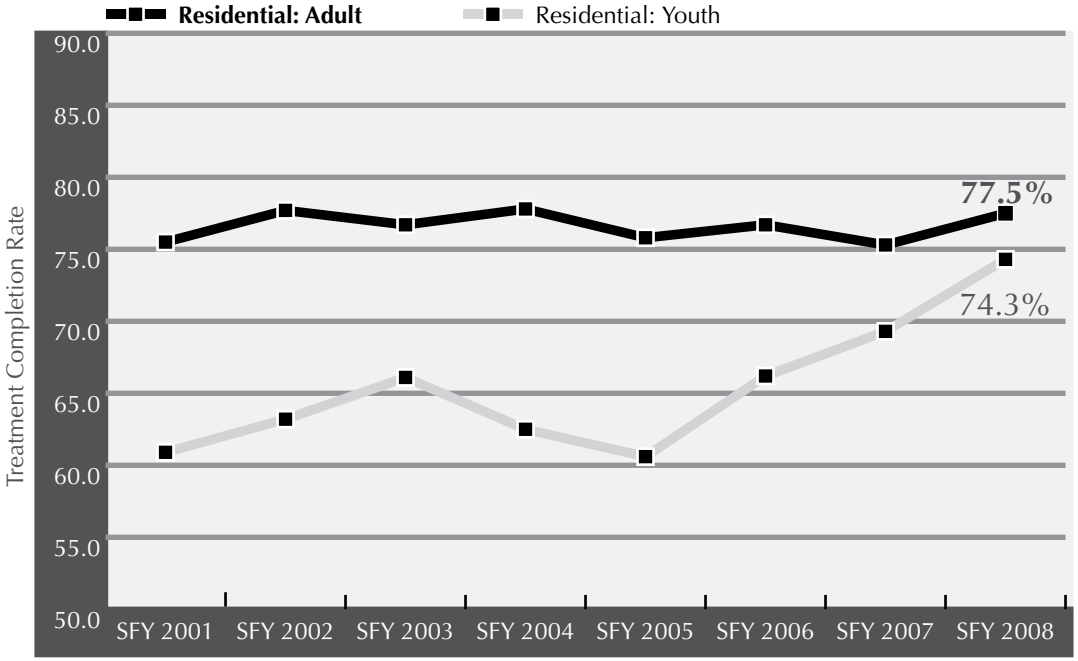
***As part of the Department of Social and Health Services' pledge to ensure better outcomes for the state residents it serves, the Division of Behavioral Health nd Recovery (DBHR) has committed itself to improving completion and retention rates for publicly funded patients receiving chemical dependency treatment.***

Multiple studies, conducted in Washington State and elsewhere, demonstrate that outcomes following from treatment participation are significantly enhanced when patients complete treatment. For example, relative to patients who did not complete treatment, completers have been found to:

- Have higher employment and wages following discharge from treatment.
- Be arrested and convicted less frequently after discharge.
- Have significantly fewer inpatient medical hospital admissions and are less likely to require emergency medical services after discharge.
- If pregnant, are more likely to have full-term deliveries, babies with higher birth weights, and fewer fetal or infant deaths.
- Produce higher cost savings to public systems following discharge.

In the pages that follow, results from studies that illustrate the above points are featured. All studies have been conducted in Washington State with publicly funded clients. Taken together, they suggest that improving treatment completion rates is one of the most powerful ways to maximize benefits from the limited public resources available to fund chemical dependency treatment. DBHR is working with researchers, counties, tribes, and both residential and outpatient treatment providers to set targets and incorporate best practices to improve completion rates throughout the state.

# Three-Quarters of Adults and More than Two-Thirds of Youth Who Enter Residential Treatment Complete It.

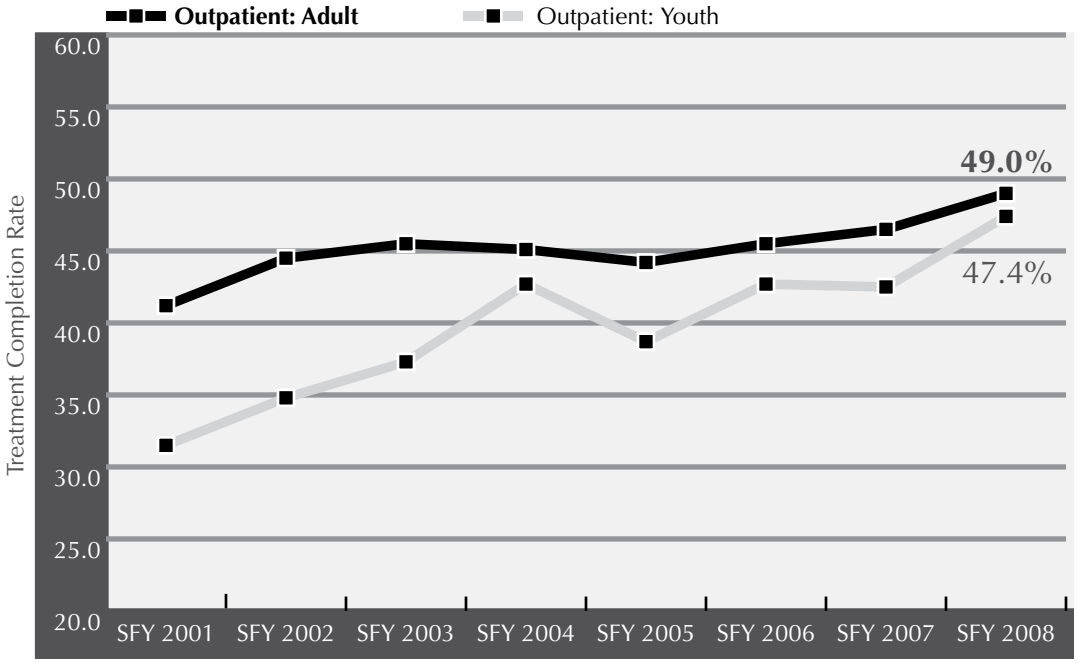



Source: Program Review, Division of Behavioral Health and Recovery, September 2009.

The Division of Alcohol and Substance Abuse has set a goal of increasing the percentage of low-income and indigent adults and youth who complete publicly funded chemical dependency treatment. Research has demonstrated that treatment completion is closely linked to better outcomes for both adults and youth.

A critical concern is that once residential treatment is completed, continuity of care is maintained through transition of patients back to outpatient treatment in the community.

# Outpatient Completion Rates for Both Adults and Youth Have Risen Significantly Since SFY 2001.

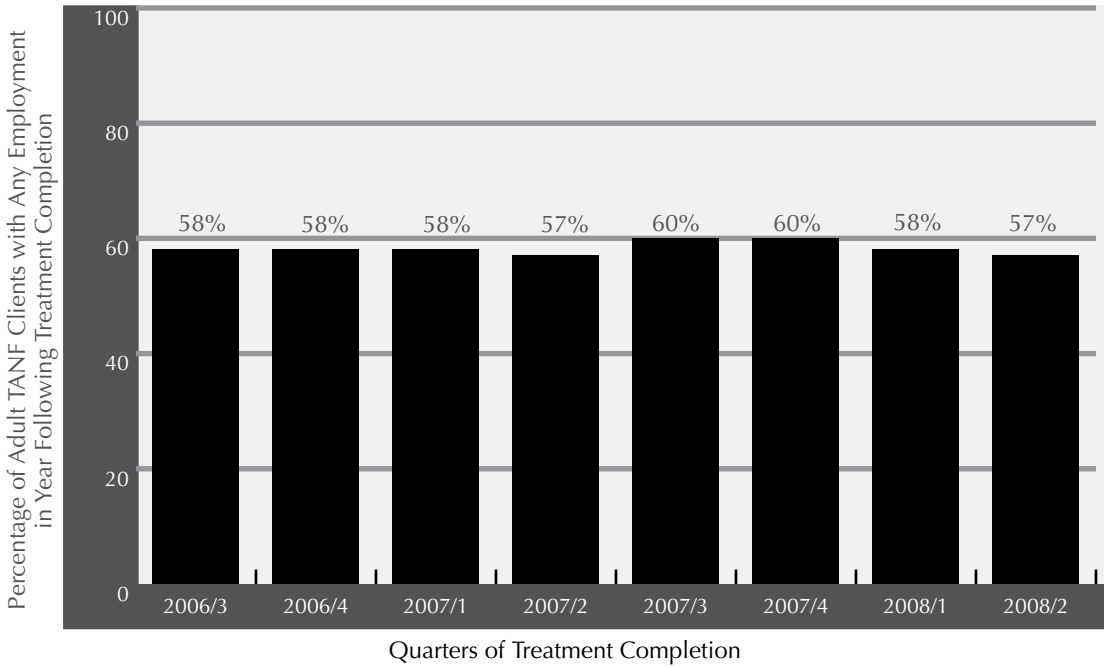



Source: Program Review, Division of Behavioral Health and Recovery, September 2009.

The Division of Alcohol and Substance Abuse has set a goal of increasing the percentage of low-income and indigent adults and youth who complete publicly funded chemical dependency treatment. Research has demonstrated that treatment completion is closely linked to better outcomes for both adults and youth.

Patients receive outpatient treatment either as their primary modality of care or after completing a course of residential treatment. This graph indicates that outpatient completion rates are rising, with youth outpatient completion rates increasing by 51% since SFY 2001.

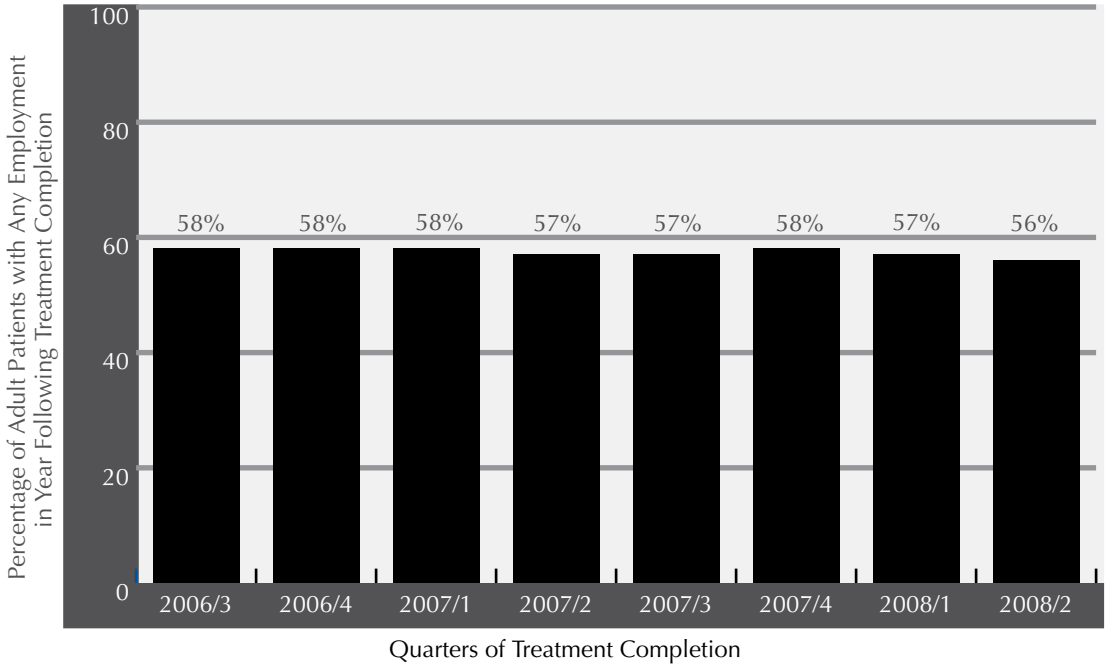
# On Average, More than Half of Adult Clients Enrolled in the Temporary Assistance for Needy Families (TANF) Program and Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.




Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

This graph indicates that of clients enrolled in the Temporary Assistance for Needy Families (TANF) program who completed chemical dependency treatment in the second quarter of SFY 2008, and did not require further treatment, 57% became employed in the following 12 months. Some 64% of those employed worked more than 20 hours a week; 33% earned wages above the Federal Poverty Level. For TANF clients with substance abuse problems, chemical dependency treatment helps move them toward economic self-sufficiency.

# Almost Three Out of Five Adult Patients Completing Publicly Funded Chemical Dependency Treatment Become Gainfully Employed in the Year Following Discharge.




Source: Washington State Department of Social and Health Services, Research and Data Analysis Division, 2009.

This graph indicates that almost three out of five low-income adults who completed chemical dependency treatment in the second quarter of SFY 2008, and did not require further treatment, became employed in the following 12 months. Average monthly wages were $882. Almost two-thirds of those employed (66%) worked more than 20 hours a week; 42% earned wages above the Federal Poverty Level. Chemical dependency treatment clearly helps move individuals with substance abuse problems toward economic self-sufficiency.

# Completion of Treatment and Treatment Retention are Associated with Reduced Risk of Felony Arrests Among Adults, and Convictions Among Youth.

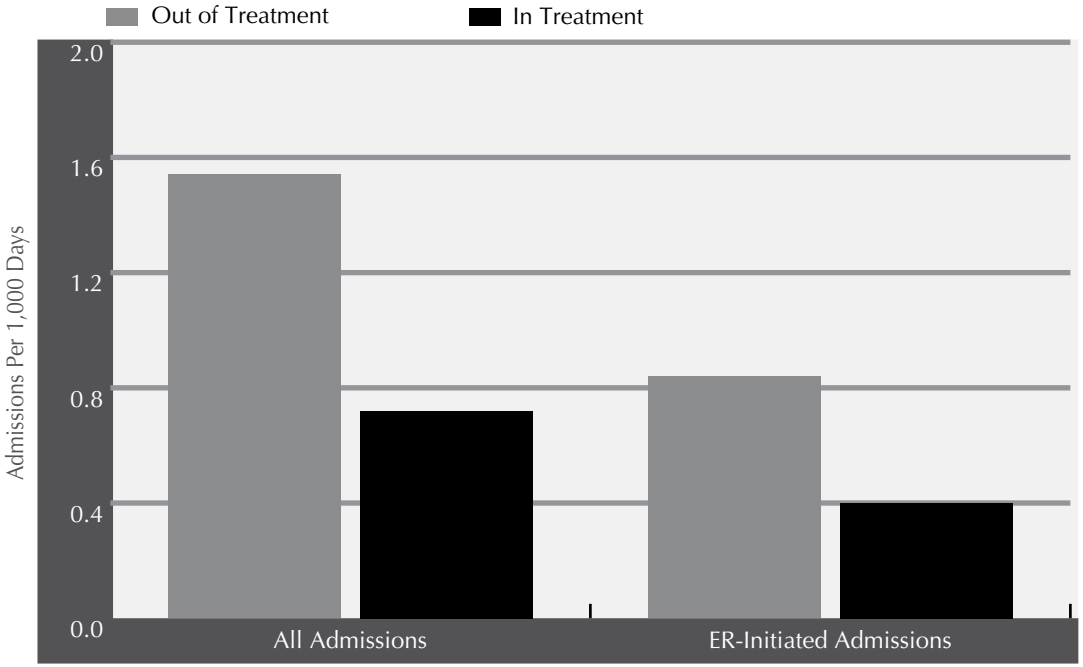
Research, both in Washington State and elsewhere, has consistently shown that admission to chemical dependency treatment is associated with lower crime rates, fewer arrests, and lower criminal justice costs. More recent studies highlight the benefits of both treatment completion and longer retention in treatment:

- A 2002 study of over 10,000 adult patients who received publicly funded chemical dependency treatment in 1995 demonstrated that the probability for a felony offense was 21% lower in the following year for patients completing treatment when compared to patients who did not complete treatment. For patients whose treatment episode was greater than 90 days, the probability of a felony arrest was 32% less than for patients with shorter treatment episodes.[1]
- A 2003 study of almost 6,000 youth who participated in substance abuse treatment between 1997 and 1998 indicated that patients completing treatment had a 29% reduction in the risk of a subsequent felony conviction, and a 17% reduction in risk of any conviction in the year following discharge, compared to non-completers.[2]



[1] Luchansky, B., et al. *Substance Abuse Treatment and Arrests: Analyses from Washington State (Fact Sheet 4.42).* Olympia, WA: Department of Social and Health Services, Research and Data Analysis Division, 2002.
[2] Luchanski, B., et al. *Treatment Readmissions and Criminal Recidivism in Youth Following Participation in Chemical Dependency Treatment. Journal of Addictive Diseases* 25(1), 2006.

# Opiate Substitution Treatment Patients are Less Likely to Be Admitted to Hospitals While in Treatment.




Source: Luchansky, B.,et al., "Inpatient Hospital Admissions for Clients in Opiate Substitution Treatment: Longitudinal Analyses from Washington State," *Substance Use and Misuse* 32, 2007.

A recent study conducted for the Division of Alcohol and Substance Abuse reported that publicly funded opiate substitution treatment patients were significantly more likely to be admitted to a hospital while they were out of treatment as compared to when they were in treatment. Patients in treatment were 33% less likely to experience a hospital admission than those who left treatment. Most of the hospital admissions came through either the emergency room (56%) or through an urgent care facility (21%). Such acute care services are among the most costly. Medicaid or Medicare paid for 82% of these hospital admissions; only 15% were paid by a private payer.[1] Thus, retention in opiate substitution treatment results in better health for patients, and lower costs to the public.

[1] Luchansky, B.,et al. "Inpatient Hospital Admissions for Clients in Opiate Substitution Treatment: Longitudinal Analyses from Washington State." *Substance Use and Misuse* 32, 2007.

# Longer Retention in Opiate Substitution Treatment is Associated with Higher Methadone Dose.

| | Average Peak Methadone | Average Number of Days in Treatment |
|---|---|---|
| Opiate Substitution Treatment Program #1 | 109 mg/day | 284.2 |
| Opiate Substitution Treatment Program #2 | 83.1 mg/day | 193.5 |

Source: Carney, M., et al., *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

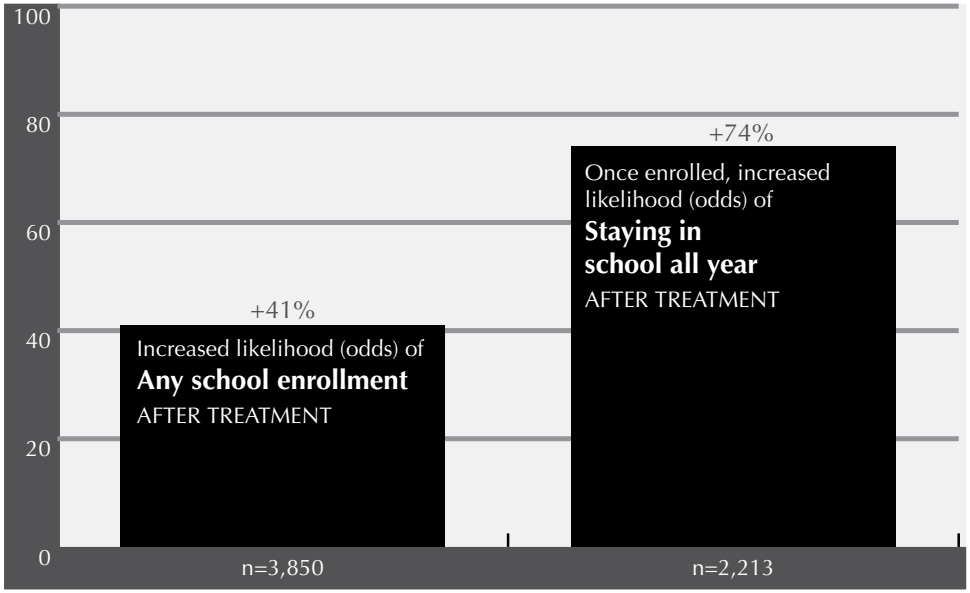
A 2003 study of 135 individuals admitted to two Washington State opiate substitution treatment programs found a close association between average peak methadone dose and average number of days in treatment. Patients in the programs where average peak dose was 109 mg/day remained in treatment an average of 90.7 days longer than those in the program where average peak dose was 83.1 mg/day, a difference of 46.8%. In addition, it was found that patients whose peak methadone dose was less than 75 mg/day were significantly more likely to leave treatment prior to 170 days. The mean peak methadone dose for patients who left treatment prior to 170 days was 78.0 mg/day, compared with a peak dose of 104.6 mg/day for those who remained in treatment at least 170 days.[1]

Longer retention in opiate substitution treatment is associated with better outcomes: less crime and involvement with the criminal justice system, fewer medical hospitalizations and emergency room visits, lower medical costs, fewer psychiatric hospitalizations, and less reliance on public assistance.



[1] Source: Carney, M., et al. *Washington State Outcomes Project: Opiate Study Sample. Final Report.* Seattle, WA: University of Washington, Alcohol and Drug Abuse Institute, 2003.

# High School Youth Ages 15-17 Who Complete Chemical Dependency Treatment Significantly Increase Their Likelihood of Staying in School Beyond Those Who Do Not Complete Treatment.




Source: Longhi, D., and Felver, B., "School Enrollment, School Retention, and Grades Improve Among Youth Who Complete and/or Stay Longer in Alcohol and Other Drug (AOD) Treatment." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, December 2005.

Chemical dependency treatment is associated with better outcomes for school-age youth in need of it, including lower rates of delinquent behavior, felonies and misdemeanors, and legal supervision. It is also associated with improved school outcomes, including lower school dropout rates, and better school performance.

A recent study of youth ages 15-17 who received chemical dependency treatment found that those completing treatment were 41% more likely to be enrolled in school than those who did not complete treatment. In addition, those who complete treatment were 74% more likely to remain in school the entire year following treatment completion.[1]

[1] Longhi, D., and Felver, B. "School Enrollment, School Retention, and Grades Improve Among Youth Who Complete and/or Stay Longer in Alcohol and Other Drug (AOD) Treatment." Olympia, WA: Washington State Department of Social and Health Services, Research and Data Analysis, December 2005.

# Data Sources

# Data Sources

*Tobacco, Alcohol, and Other Drug Abuse Trends in Washington State – 2008* contains information and data from a wide variety of federal and state government agencies. Given the diverse indicators included in this Report, data sources differ significantly with regard to methodology, sampling and collection procedures, as well as in the reliability and validity of the data. Report users are encouraged to consult the original data sources for more detailed information.

## *National Sources*

**Monitoring the Future (MTF)** (www.isr.umich.edu/src/mtf)

Conducted by the Institute for Social Research, University of Michigan, and supported by research grants from the National Institute on Drug Abuse, the Monitoring the Future (MTF) project studies changes in the beliefs, attitudes, and behavior of young people in the United States. Surveys have been carried out each year since 1975. Students in the 8th, 10th, and 12th grades complete self-administered, machine-readable questionnaires in their classrooms. Surveys are administered from February to May, invalidating direct comparisons with results from a similar survey – the Washington State Healthy Youth Survey – which is administered in October. Data are used to monitor trends in substance use and abuse among adolescents, and progress toward national education goals for safe, disciplined, and alcohol- and drug-free schools. Results are also used in development of the White House National Drug Control Strategy.

**National Institute on Drug Abuse (NIDA)** (www.nida.nig.gov/)

The mission of the National Institute on Drug Abuse (NIDA) is to lead the nation in bringing the power of science to bear on drug abuse and addiction. NIDA seeks to accomplish this mission through the strategic support and conduct of research across a broad range of disciplines. NIDA supports over 85% of the world's research on health-related aspects of drug abuse and addiction. NIDA also works to ensure the rapid and effective dissemination and use of results from research to significantly improve drug abuse and addiction prevention, treatment, and policy. NIDA is one of the 19 institutes that comprise the National Institutes of Health (NIH), the principal biomedical research agency of the federal government.

**National Institute on Alcohol Abuse and Alcoholism (NIAAA)** (www.niaaa/nih/gov/)

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) is one of 19 institutes that comprise the National Institutes of Health (NIH). NIAAA provides leadership in the national effort to reduce alcohol-related problems by:

- Conducting and supporting research in a wide range of scientific areas including genetics, neuroscience, epidemiology, health risks of alcohol consumption, and the benefits of prevention and treatment.
- Coordinating and collaborating with other research institutes and federal programs on alcohol-related issues.
- Collaborating with international, national, state, and local institutions, organizations, agencies, and programs engaged in alcohol-related work.

# Data Sources

- Translating and disseminating research findings to health care providers, researchers, policymakers, and the public.

NIAAA-supported research and direction are aimed at:

- Removing the stigma associated with the common and complex disease of alcoholism.
- Revealing genetic, other biological, and sociocultural origins of variations in individual responses to alcohol and the consequent risks and benefits of alcohol to health.
- Developing effective prevention and treatment programs that address the physical, behavioral, and social risks attributable to excessive and underage alcohol consumption, and the chronic relapsing nature of alcoholism.
- Improving the acceptance of, and access to, quality care.

**Bureau of Justice Statistics (BJS)** (www.ojp.usdog.gov/bjs/)

The Bureau of Justice Statistics (BJS), part of the Office of Justice Programs within the U.S. Department of Justice, is the nation's leading source for criminal justice-related data. BJS collects, analyzes, publishes, and disseminates data on crime, criminal offenders, victims of crime, and the operation of, and expenditures related to, justice systems at all levels of government. These data are used by federal, state, and local policymakers.

Annually, BJS publishes *Bureau of Justice Statistics Key Crime Statistics at a Glance*, a summary of information and data most recently gathered. This report can be found at www.ojp.usdoj/bjs/glance.htm#Crime.

**Federal Bureau of Investigation (FBI) – Uniform Crime Reports** (www.fbi.gov/ucr/ucr.htm)

The Federal Bureau of Investigation's (FBI) Uniform Crime Reporting Program (UCR) collects crime statistics from nearly 17,000 law enforcement agencies across the United States, covering approximately 95% of the population. Data are gathered by state and local agencies and submitted to the FBI. Data related to eight categories of crime are gathered: 1) murder and nonnegligent manslaughter; 2) forcible rape; 3) robbery; 4) aggravated assault; 5) burglary; 6) larceny-theft; 7) motor vehicle theft; and 8) arson.

The primary limitation of UCR is that it measures reported crime rather than all crimes committed. Reported levels may vary from community to community as a result of a wide variety of factors, including funding and aggressiveness of local law enforcement agencies. The FBI operates two other reporting systems. The National Crime Victimization Survey collects data on unreported as well as reported crime by surveying a representative sample of households. The National Incident-Based Reporting Systems presents comprehensive, detailed information about crime incidents to law enforcement, researchers, and planners.

# Data Sources

**Centers for Disease Control and Prevention (CDC)** (www.cdc.gov)

The Centers for Disease Control and Prevention (CDC) is the lead federal agency charged with protecting the health and safety of Americans, providing information for making health decisions, and promoting and protecting the nation's health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control strategies, environmental health approaches, and health promotion and education activities. There are 11 national centers.

**National Center for Injury Prevention and Control (NCIPC)** (www.cdc.gov/ncipc/)

The National Center for Injury Prevention and Control (NCIPC) works to reduce morbidity, disability, mortality, and costs associated with injuries occurring outside the workplace. One of the 11 federal Centers for Disease Control and Prevention, NCIPC conducts and supports research about causes, risk factors, and preventive measures for injuries outside the workplace, including:

- Unintentional injuries related to falls, fires, drowning, poisoning, motor vehicle crashes (including those involving pedestrians), sports and recreational activities, and playgrounds and day-care settings.
- Intentional injuries related to homicide, suicide, youth violence, intimate partner violence, child maltreatment, and sexual violence.
- Improving health and quality of life after injuries and preventing secondary conditions among people with disabilities.

NCIPC also funds research by universities and other public and private groups studying the three phases of injury control (prevention, acute care, and rehabilitation) and the two major disciplines of injury control (epidemiology and biomechanics).

**National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) – Division of Sexually Transmitted Diseases** (www.cdc.gov/nchhstp)

CDC's Division of Sexually Transmitted Diseases (STDs) provides national leadership through research, policy development, and support of effective services to prevent STDs (including HIV infection) and their complications, such as enhanced HIV transmission, infertility, adverse outcomes of pregnancy, and reproductive tract cancers. The Division assists health departments, health care providers, and non-governmental organizations and collaborates with other governmental entities through the development, syntheses, translation, and dissemination of timely, science-based information; the development of goals and science-based policy; and the development and support of science-based programs that meet the needs of communities.

The HIV/AIDS Surveillance Report (www.cdc.gov/hiv/topics/surveillance/resources/reports/index.htm) is published annually by the Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, CDC. It contains data about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, gender, race/ethnicity, age, vital status, and case definition category.

# Data Sources

**National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHSTP) – Division of Tuberculosis Elimination (DBTE)** (www.cdc.gov/nchhstp/tb/surv/surv.htm)

The NCHSTP Division of Tuberculosis Elimination (DTBE) seeks to provide leadership in preventing, controlling, and eventually eliminating tuberculosis (TB) in the U.S., in collaboration with partners at the community, state, and international levels. To accomplish this mission, the DTBE carries out the following activities:

- Develops and advocates effective and appropriate TB prevention and control policies.
- Supports a nationwide framework for monitoring TB morbidity and mortality.
- Detects and investigates TB outbreaks.
- Conducts clinical, epidemiological, behavioral, and operational research to enhance TB prevention and control efforts.
- Evaluates prevention effectiveness.
- Provides funding and technical assistance to state and local health departments.
- Provides training, education, and technical information services to state and local health departments.

DBTE publishes an annual TB Surveillance Report. The reports include statistics on tuberculosis case counts and case rates by states and metropolitan statistical areas with tables of selected demographic and clinical characteristics (e.g., race/ethnicity, age group, country of origin, form of disease, drug resistance, etc.).

**Behavioral Risk Factor Surveillance System (BRFSS)** (http://www.cdc.gov/brfss)

CDC's National Center for Chronic Disease Prevention and Health Promotion administers the Behavioral Risk Factor Surveillance System (BRFSS), the world's largest telephone survey. Based on an understanding that personal health behaviors play a major role in premature morbidity and mortality, BRFSS facilitates the collection of behavior-related data on a state-specific basis. State-level surveillance of prevalence of major behavioral risks assists states in planning, initiating, supporting, and evaluating health promotion and disease prevention programs.

**National Center for Health Statistics (NCHS)** (www.cdc.gov/nchs)

CDC's National Center for Health Statistics (NCHS) provides statistical information to be used by policymakers and health professionals to improve the health of the American people. As the nation's principal health statistics agency, NCHS is responsible for providing accurate, relevant, and timely data. NCHS has two major types of data systems: those based on populations, containing data collected through personal interviews or examinations; and those containing data collected from vital and medical records.

# Data Sources

**National Highway Traffic Safety Administration – Fatality Analysis Reporting System (FARS)** (www-fars.nhtsa.dot.gov)

The Fatality Analysis Reporting System (FARS) facilitates the collection and reporting of data for all fatal crashes involving automobiles in the United States, and provides a basis for evaluation of overall highway safety, motor vehicle safety standards, and highway safety initiatives and programs. FARS maintains cooperative agreements with agencies in each state to collect and report fatal crash data in a standard format. Data is available through a web-based "encyclopedia".

# Data Sources

## *State Sources*

**Washington State Department of Social and Health Services, Divisions of Behavioral Health and Recovery - TARGET**

TARGET (Treatment Assessment Report Generation Tool) is a reporting management information system used by the Washington State Department of Social and Health Services, Division of Behavioral Health and Recovery. Reporting is required for treatment agencies providing public sector-contracted/funded treatment services and optional for private pay individuals served. TARGET information collection is based on establishing a baseline at admission to treatment and capturing/identifying changes to that baseline upon discharge, thus providing information on progress during treatment.

**Office of Financial Management – Population Trends for Washington State** (http://www.ofm.wa.gov)

The Office of Financial Management (OFM) provides official population counts and estimates. Population figures reported by OFM include all persons who normally reside in the state, including military personnel and dependants, persons in correctional institutions, residents of nursing care facilities, and college students.

**Washington State Department of Health – Center for Health Statistics** (http://www.doh.wa.gov/ehsphl/CHS-ddata/main.htm)

Data used come from Certificates of Live Birth, Fetal Death, Death, Marriage, and Dissolution. Washington State Vital Statistics are compiled each year from certificates received before April 15 of the previous year.

**Washington State Department of Health, Office of Hospital and Patient Data System – Comprehensive Hospital Abstract Reporting System** (www.doh.wa.gov/EHSPHL/hospdata/Chars.htm)

The Washington State Department of Health's Comprehensive Abstract Reporting System (CHARS) monitors hospital admission trends, causes of hospitalization, and other indices used to evaluate the quality and accessibility of health care in Washington. Key data elements include patients' age, sex, physician, primary and secondary diagnoses, principal and secondary procedures, length of stay, and discharge status.

CHARS does not include data from federal, military and Veteran's Administration hospitals. Also excluded from the system are emergency room visits, data from outpatient facilities, surgery centers, birthing centers, and free-standing mental health, substance abuse, and rehabilitation centers or clinics.

**Washington Traffic Safety Commission** (http://www.wa.gov/wtsc/index.htm)

Collaboration among state, federal, and local partners is key in designing and implementing successful traffic safety programs. Each year the federal government allocates part of the federal Highway Trust Fund to the states to carry out highway safety programs. The Washington Traffic Safety Commission (WTSC) has administered these funds and facilitated these efforts in Washington State since 1967. Governor Christine Gregoire serves as WTSC chair. WTSC offers several programs, including the following: Impaired Driving, Community DUI & Traffic Safety Programs, Occupant Protection, Police, Traffic Records and Research, Youth, College-Age, Pedestrian/Bicycle, and Public Information and Education.

**Washington State Healthy Youth Survey (HYS)** (http://fortress.wa.gov/doh/hys)

The Washington State Healthy Youth Survey provides information about the health attitudes and behaviors of Washington youth. A student survey has been conducted in Washington in even-numbered years since 1988, under the auspices of the Office of Superintendent of Public Instruction (OSPI). HYS includes a sample of public school students in 6th, 8th, 10th, and 12th grades. The survey provides information on tobacco, alcohol, and other drug use; violence; related risk and protective factors, and demographics (age, race, and gender).

Survey samples are selected using a stratified cluster sampling procedure, with schools being the primary sampling unit. Data from student surveys are useful for obtaining statewide estimates of the prevalence of health risk behaviors among youth, examining trends and patterns in risk behaviors, and establishing profiles of persons at risk. Caveats related to the data include:

- The student survey does not represent youth who have dropped out of school. It is thought that these youth are the most likely to engage in high-risk behavior.
- Health risk behaviors may be underestimated as it is self-reported. Willingness to self-report behavior is subject to social acceptability norms.
- Changes in time of year for survey administration means that students may differ in age and experience from survey to survey, and seasonality factors may affect results. In such instances (as in 2002), data may not be comparable with previous surveys or with national surveys conducted at a different time of year.

Washington State
Department of Social
& Health Services

**DBHR** Division of Behavioral
Health and Recovery
www.dshs.wa.gov/dasa

DSHS 22-055 (Rev 12/09)

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